SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Vincenzo Carannante
Phone: (860) 251-5096
Fax: (860) 251-5311
vcarannante@goodwin.com
Admitted in Massachusetts, Connecticut and Rhode Island

August 28, 2015

Via Hand-Delivery

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: CON Application

Dear Ms. Martone:

On behalf of The Hospital of Central Connecticut, enclosed please find a Certificate of Need Application for the termination of its inpatient and outpatient pediatric services. As requested, I have included 1 original and 4 hard copies of the Certificate of Need Application in 3-ring binders and a CD with the electronic version of the enclosed documents and materials. Also attached to this letter is a check for the $500.00 filing fee.

Please do not hesitate to contact me at 860-251-5096 if you have any questions.

Sincerely,

Vincenzo Carannante

Application Checklist

Instructions:

1. Complete the following checklist and **submit** as the first page of the CON application:

☒ Attached is a paginated hard copy of the CON application (all social security numbers must be redacted), including a completed affidavit, signed and notarized by the appropriate individuals.

☒ (**New**). A completed supplemental application form specific to the proposal type, available on OHCA's website under OHCA Forms (see previous page for the list of supplemental forms).

☒ Attached is the CON application filing fee in the form of a check made out to the "Treasurer State of Connecticut" in the amount of $500.

☒ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

☒ Attached is a completed Financial Worksheet (A, B or C) available at OHCA's website under OHCA Forms.

☒ Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.

☒ The following have been submitted on a CD:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format; and
2. An electronic copy of the completed application forms in **MS Word** (the applications) and **MS Excel** (Financial Worksheet)

For OHCA Use Only:

Docket No.: 15-32023-ROW **Check No.:** 003187

OHCA Verified by: SWC **Date:** 9/1/15

HARTFORD HEALTHCARE
ATTN: ACCOUNTS PAYABLE
PO BOX 5037
HARTFORD, CT 06102-5037

51-57
119

Check Number
003181
Bank of America

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

Five hundred and 00/100 Dollars

Pay to the order of

STATE OF CONNECTICUT
DEPT OF PUBLIC HEALTH
DIV. OF HEALTH SYSTEMS REGULATIONS
PO BOX 1080
HARTFORD, CT 06105

Date: 08/27/2015

Payment Amount: *******$500.00

VOID AFTER 90 DAYS

THE BACK OF THIS DOCUMENT CONTAINS LAID LINES AND AN ARTIFICIAL WATERMARK. HOLD AT AN ANGLE TO VIEW.

[redacted]

STATE OF CONNECTICUT
DEPT OF PUBLIC HEALTH
DIV. OF HEALTH SYSTEMS REGULATIONS
PO BOX 1080
HARTFORD, CT 06105

Entity	Vendor ID / Location	Check Number
30100	1000008112	003181

HARTFORD HEALTHCARE

Invoice Number	Invoice Date	Gross Amount	Discount Amount	Withholding Amount	Net Amount
C082615100000811250000	08/26/2015	500.00			500.00

08/28/15

0002

HH571485 1/03

TOTALS $500.00 0.00 0.00 $500.00

Affidavit

Applicant: The Hospital of Central Connecticut

Project Title: Termination of Inpatient and Outpatient Pediatric Services

I, **Lucille Janatka, Sr. Vice President Hartford HealthCare and President of Hartford HealthCare Central Region**
(Name) (Position – CEO or CFO)

of **The Hospital of Central Connecticut** being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 8/24/15

Subscribed and sworn to before me on 8/24/15

_____
Notary Public/Commissioner of Superior Court

My Commission Expires March 31, 2016

My commission expires: _____

Public Notice Filing for Hospital of Central Connecticut Transition of Inpatient and Outpatient Pediatric Services

Statutory Reference:	Connecticut General Statutes §19a-638
Applicant:	Hospital of Central Connecticut
Project Address:	New Britain General Campus New Britain, Connecticut 06050
Proposal:	The Applicant intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access to transition inpatient and outpatient pediatric services to community providers.
Capital Expenditure:	none

052214

SOUTHINGTON POLICE BLOTTER

Southington police report the following:

Stephen F. Brown-Boone, 33, of 625 Quen St., was charged May 15 with disorderly conduct.

Miles D. Groom, 20, of 84 Pleasant St., was charged May 15 with driving under the influence and failure to drive right.

Pedro Juan Rodriguez, 39, of 64 Wheeler Village, was charged May 16 with disorderly conduct, second degree breach of peace, second degree threatening and carrying a dangerous weapon.

Phyllis R. Soderberg, 61, of 81 Lady Slipper Lane, was charged May 16 with operating an unregistered motor vehicle.

Doyle P. McLean, 31, of 34 Neagle St., Naugatuck, was charged May 16 with operating an unregistered motor vehicle.

David W. Childs, 45, of 31 Sylvester St., Bristol, was charged May 16 with operating an unregistered motor vehicle and operating a motor vehicle without insurance.

Michael Thai, 50, of 39 Bingham St., Bristol, was charged May 16 with operating an unregistered motor vehicle.

Dorothy J. Perugini, 31, of 174 Summer St., was charged May 16 with operating an unregistered motor vehicle.

Nicholas Petosa, 19. of 30 Walnut St., was charged May 16 with failure to drive in proper lane.

Allison M. Perkins, 34, of 222 West Main St., Plantsville, was charged May 16 with driving under the influence and failure to drive right.

Jessica Lynn Sanderson, 26, of 43 Earl St., Waterbury, was charged May 16 with driving under the influence, weapon in a motor vehicle and operating a motor vehicle without a license.

Marek L. Raskiewicz, 37, of 300 Pershing Ave., New Britain, was charged May 17 with evading responsibility and operating a motor vehicle without insurance.

Scott T. Muenchow, 53, of 39 Berkley Ave., was charged May 15 with operating an unregistered motor vehicle.

Gene Stewart Jr., 30, of 138 Mountain Edge Drive, was charged May 18 with operatng a motor vehicle under suspension.

Maryann S. Drennen, 48, of 246 Garden St., Wethersfield, was charged May 18 with failure to grant right of way.

Peter N. Martin, 20, of 154 Meadowview Ave., Stratford, was charged May 18 with breach of peace and 3rd degree assault. David Pippa, 44, of 51 Union St., was charged May 19 with disorderly conduct.

Hospital of Central CT to move pediatric practice

Continued from Page 1

Washington St., New Britain, and other providers.

"After careful consideration, and in light of declining utilization, we have decided to transition pediatric care to respected organizations," announced Lucille Janatka, regional president of Hartford HealthCare, of which HOCC is a part.

The full transition will be completed within a year.

"This actually won't change much of what we're already doing," said Dr. Steven Hanks, regional vice president of medical affairs. There hasn't been pediatric patient admitted into the unit in six months, he noted; the few who needed to be hospitalized have been transferred to the nationally ranked Connecticut Children's Medical Center in Hartford. Prior to that, the department averaged two patients a day for the last several years.

"At CCMC, pediatric patients will receive comprehensive and more specialized care," Janatka said. "CCMC has been named among the best for its pediatric care by U.S. News & World Report and is the only free-standing children's hospital in the state. In fact, CCMC already has a long history of serving patients in our community."

The New Britain hospital's pediatric services have been limited to one practitioner for the past several years, Hanks said, which made it very difficult to cover when that person was on vacation or otherwise off work. And it was even harder to justify the expense when on-call and other hospital services were included. Hanks said about $1 million a year has been spent in recent years to maintain and improve the department, but that the hoped-for expansion "never materialized." Advances in medicine made it possible for most children to be treated in an office and sent home, changing the need for services from inpatient to outpatient. The hospital is requesting a change in its Certificate of Need for its "menu of services" in pediatrics.

Community Health Services, which operates from its Washington Street clinic, will receive a higher Medicaid reimbursement than the hospital does, which will provide stability and allow expansion there.

"This will provide a richer and broader array of services," Hanks said, pointing out the dental, mental health and social support services offered by CHS, all of which the hospital referred to other providers.

"It's all about offering better care," said Rebecca Stewart, director of media relations for Hartford HealthCare.

Pediatric patients and their families will have the option of using any health resources that they choose to.

The action will have no effect on the hospital's emergency services, neonatal intensive care unit and birthing center. Children will continue to be seen in emergency department, and either treated and released or transfered to Connecticut Children's Medical Center.

"Please know that The Hospital of Central Connecticut will continue to provide 24/7 care for pediatrics in its Emergency Department," Janatka said in her statement. "We also remain committed to one of our key strengths – care of the newborn – within our Family BirthPlace and neonatal intensive care unit."

In the future, the network will grow to include pediatricians throughout the state as part of a team approach. "No one is being abandoned," Stewart said.

Public Notice Filing for The Hospital of Central Connecticut Transition of Inpatient and Outpatient Pediatric Services

Statutory Reference:	Connecticut General Statutes §19a-638
Applicant:	The Hospital of Central Connecticut
Project Address:	New Britain General Campus New Britain, Connecticut 06050
Proposal:	The Applicant intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access to transition inpatient and outpatient pediatric services to community providers.
Capital Expenditure:	none

052234

Peter P. Dzubay

Peter P. Dzubay, 99, of Berlin, widower of Rose Marie Dzubay, died peacefully at Middlesex Hospital Hospice on Sunday, May 24. He was born on Aug. 29, 1915, in Simpson, Pa. He was the son of The Rev. Peter P. Dzubay and Dominica (Bialys) Dzubay.

He graduated from Crosby High School in Waterbury in 1933 and The University of Chicago with a Masters of Business Administration in 1940. Peter married Rose Marie Wiedorn on June 5, 1948, and was married 63 years prior to her death in 2012.

He was employed by Northeast Utilities in Berlin, where he retired in 1980 after 35 years. He served in the U.S. Naval Reserve including World War II active duty from 1941-1945, retiring in 1975 with the rank of Commander. Peter was a member of Berlin Congregational Church. He will be missed by all who knew him.

He leaves behind his five sons, Peter Dzubay of Breckenridge, Colo.; Mark Dzubay and his wife, Jill (Rossi), of Leadville, Colo.; John Dzubay of Berlin; Gregory Dzubay of Berlin; and Carl Dzubay and his wife, Dawn (Swain), of Southbury; and his sister, Marsha (Dzubay) Tillson of Shortsville, N.Y. He also leaves behind five grandchildren he adored and cherished, Mikelle Rose (Dzubay) Dubois and her husband, Matt; David Peter Dzubay, Lindsay Joy Dzubay, Christy Dawn Dzubay and Peter Carl Dzubay.

Funeral services are Friday, May 29, 2015, 2 p.m. at Berlin Congregational Church, 878 Worthington Ridge, Berlin CT 06037, followed by burial in Maple Cemetery with military honors. There are no calling hours. Carlson Funeral Home, New Britain, is in charge of arrangements. In lieu of flowers, donations can be made to the Berlin Congregational Church. Please share a memory or note of sympathy at www.carlsonfuneralhome.com

Jason Augeri

Jason Augeri, 41, of Southington passed away on Monday, May 25, 2015.

He was born on March 20, 1974 in New Britain, the son of Janet (Dombrowski) Augeri Niksa and her husband, Leon, of Southington and the late Dan Augeri. He served for two years in the U.S. Navy. Jason was employed by Walmart. He enjoyed railroad trains and space shuttles.

In addition to his mother, he is survived by a daughter, Hannah Viola Augeri; a brother, Scott Augeri of Springfield, Mass., and his two children, Victoria and Scotty, and their mother, Urszula Augeri, of Farmington; his maternal grandmother, Sophie Dombrowski of Southington; uncle, Robert Domrowski, aunt, Lisa Dombrowski and a nephew, Ryan Dombrowski, all of Farmington. He also leaves the mother of his daughter, Lisa Martin of Burlington.

Funeral services will be held Friday at 5 p.m. at the DellaVecchia Funeral Home, 211 N. Main St., Southington. Calling hours will be Friday from 3 p.m. until the time of service. Burial will be at the convenience of the family.

For online condolences and directions visit www.dellavecchiafh.com

Philip Louis Ouellette

Philip Louis Ouellette, 94, of New Britain died early Sunday morning, May 24, 2015, at the Hospital of Central Connecticut in New Britain. Born in Caribou, Maine, he lived most of his life in New Britain. He was predeceased by his wife, Thelma (Skidgel) Ouellette. He served his country during World War II in the U.S. Army, and was a member of the Teamsters Union during his career.

Mr. Ouellette is survived by two sons and a daughter, Roy and his wife, Mindi Ouellette, of Buena Vista, Va., Leo and his wife, Antoinette Ouellette, of Southington and Phyllis and her husband, Steve Fentner, of Bristol; eight grandchildren; nine great- grandchildren; two brothers, Robert and his wife, Alice Ouellette, of Stockholm, Maine, and Gilbert and his wife, Joyce Ouellette, of Calabash, N.C., and several nieces and nephews.

Funeral services will be private and at the convenience of the family, with burial in the Veteran's Section of Fairview Cemetery. In lieu of flowers, donations may be made to the Veteran's of Foreign Wars.

To light a candle or send a condolence, please visit www.FarrellFuneralHome.com.

Jacqueline J. (Whitney) Coffey

Jacqueline J. (Whitney) Coffey, 78, of New Britain died Tuesday, May 26, 2015, at St. Mary's Home in West Hartford. Born in New Britain, the daughter of the late John and Florence (Young) Whitney, she was a lifelong resident. She had been employed for many years at the University of Hartford, retiring in 2000 and was a member of St. Andrew's Church.

Mrs. Coffey is survived by four daughters, Sharon Coffey of New Britain, Eileen and her husband, Robert Kristof, of East Hartford, Maureen Coffey and Colleen Coffey, both of New Britain. She also leaves behind the family of a special friend, the late Edward Dutkiewicz.

A memorial service will be held Friday, May 29, 2015, at 1 p.m. at the Farrell Funeral Home, 110 Franklin Square, New Britain. Burial will be private. In lieu of flowers, donations may be made to St. Andrew's Church, 396 Church St., P.O. Box 515 New Britain, CT 06050. To light a candle or send a condolence, please visit www.FarrellFuneralHome.com.

AROUND THE TOWNS

AREAWIDE

THE CONNECTICUT CABARET THEATRE AUDITIONS: Connecticut Cabaret Theatre in Berlin will hold open auditions for female performers to star and be featured in upcoming musicals and plays. Those auditioning are asked to prepare two songs showcasing vocal talent and a monologue. Auditions may be scheduled by contacting (860) 829-1248 or email resume and head shot to ctcabaret@msn.com. Auditions will be scheduled up until the end of May.

CRAFT ARTISTS SOUGHT: Craft artists are sought for the 89th Yankee Peddler Craft Fair to be held from 9 a.m. to 2 p.m. Saturday, Nov. 21, at the Berlin Congregational Church, 878 Worthington Ridge, Berlin. Rental fee is $40 for an 8' table and chair. For an application, call Tina at (860) 261-4321. The church is handicap accessible.

Public Notice Filing for The Hospital of Central Connecticut Transition of Inpatient and Outpatient Pediatric Services

Statutory Reference:	Connecticut General Statutes §19a-638
Applicant:	The Hospital of Central Connecticut
Project Address:	New Britain General Campus New Britain, Connecticut 06050
Proposal:	The Applicant intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access to transition inpatient and outpatient pediatric services to community providers.
Capital Expenditure:	none

Further crash details emerge

By LISA BACKUS
STAFF WRITER

NEWINGTON — A Southington man drove through a red light putting and into the path of an oncoming police cruiser as an officer was headed to the Grantmoor Motor Lodge on a report of a violent domestic dispute, according to police.

The crash, which occurred at the intersection of the Berlin Turnpike and Deming Street, caused the death of Jason Augeri, 41, of Southington. Officer Ryan Williams, a seven-year veteran of the Newington Police Department, was treated at an area hospital and released.

Initial reports indicate Augeri ran the red light heading west as Williams was traveling north on the turnpike around 7 a.m. Monday. Debris from the crash spread about 100 feet on both sides of the highway, Mayor Stephen Woods said Tuesday.

Police said cars were stopped at the intersection and several people saw the crash.

The Chief State Medical Examiner's Office will be conducting an investigation, including toxicology tests.

The officer had her lights and siren on as she proceeded through the intersection, said Rocky Hill Lt. Robert Catania, who heads the Mid-State Accident Reconstruction Team, which is investigating the crash.

"As the officer approached the turnpike's intersection with Deming Road, adjacent to Richard Street, a second vehicle crossed into the path of the police vehicle, traveling west against the red traffic control signal where multiple vehicles were stopped and against the warning issued by the officers fully audible and clearly identifiable vehicle, causing a collision witnessed by multiple persons," Catania said in a statement.

Newington officers are not participating in the investigation of the crash at the request of the town's acting police chief, Nicholas Miano, said Newington Sgt. Christopher Perry.

Miano declined comment. Perry said the acting chief made the decision not to involve local officers to maintain transparency.

Town Manager John Salomone said the officer is expected to return to full duties when she is physically able.

Anyone who may have seen the crash and has not spoken with police or who may have information is asked to call Catania at (860) 258-2710.

Chief, sergeant honored for bringing conference to state

By LISA BACKUS
STAFF WRITER

NEW BRITAIN – Police Chief James Wardwell and Sgt. Adam Rembisz were recently recognized with a "Bring it Home Award" for their roles in scheduling a national polygraph conference in Connecticut.


Chief James Wardwell

"We think Connecticut has an awful lot to offer and polygraph is strong in this state," Wardwell said.

The Bring It Home Awards are sponsored by the Connecticut Convention and Sports Bureau promoting the state as a great place to host large events and bring in millions of dollars in tourist revenues. Four other people were also honored May 14 for their work to bring conventions and large sporting events to the state.

The American Association of Police Polygraphists' annual conference will be held June 11–18, 2016, at Mohegan Sun. The event is expected to draw 500 association members from around the world and their families, Wardwell said. The estimated economic impact the conference will on the state is more than $1 million, according to the Connecticut Convention & Sports Bureau.

"The Connecticut Convention & Sports Bureau's 'Bring It Home Awards' recognize local residents who help to secure the booking of conventions, meetings and sports events in our state's venues and hotels," said Bureau interim President H. Scott Phelps. "It is important to thank individuals who have a commitment to bring their events to our state — along with economic activity, jobs and tax revenues they produce."

Wardwell is the vice president of the national AAPP, an organization dedicated to providing training and best practices for law enforcement polygraphists internationally.

Rembisz is also a member of the AAPP and the vice-president of the Connecticut Polygraph Association.

Wardwell started the police department's polygraph unit in the early 2000s. Rembisz is the city's third certified polygraph examiner and one of the few Polish speaking polygraph examiners in the state.

Each year the AAPP hosts a national convention in one of five regions. This year the event was slated to be hosted within Region III which encompasses all the New England states and several others from Delaware to Ohio.

The week-long conference will provide association members with a wide variety of training including the latest legal updates pertaining to polygraph, the latest in science, interview training, case studies and legal studies.

Senator's son says relationship hasn't enriched his business

Continued from Page 1

people."

The NBC story made it clear that no laws were broken by any of the companies cited in its story.

Gerratana said Total Graphic Solutions, which is owned by his wife, Jessica, who also is the Common Council's administrative supervisor, would still be in business even if his mother weren't a state senator. "No one has ever steered work to the company because my mother is a state senator — to my knowledge."

Total Graphic Solutions' gross earnings, according to records, were $980,130 from 2008 to 2015. That averages to about $122,500 a year. Gerratana said the company's clients are "Democrats from all over the state of Connecticut, from all walks of life."

Since a public financing system for statewide and legislative campaigns began in 2008, more than $80 million has been spent through the program. According to NBC Connecticut, the greatest part of the money granted to Democratic state House and Senate candidates is going to only a "handful of politically connected consultants, some with family ties to the legislature."

Gerratana said "there is more than a handful" of consultants and noted that his wife's firm made far less money than other companies cited in the story.

One company cited by NBC Connecticut pulled in nearly $1 million for consulting in 2014.

"They are making loose connections where there are none," Gerratana said.

Gerratana maintains that Total Graphic Solutions' best year was actually the year before his mother was elected four years ago. "That year the company had the largest gross earnings," he said.


Greg Gerratana


Jessica Gerratana

The story also noted that, three years ago, Greg Gerratana partnered with Christian Murray, who first started working for the Democratic House Caucus in 1998 designing direct-mail pieces. In 2012, NBC says, Murray, Gerratana & Co., a communications firm focusing on political campaigns, earned more than $430,000.

Gerratana said the story has been "a distraction" for his family, adding, "it's taken away from spending time on things that matter like our two young children."

Robert Storace can be reached at (860) 801-5202 or at rstorace@newbritainherald.com.

State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

General Information

Main Site*

MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
N/A	**4041950**	**Acute Care Hospital**	**The Hospital of Central Connecticut**

STREET & NUMBER	
100 Grand Street	
TOWN	**ZIP CODE**
New Britain, Connecticut	**06050**

*For additional sites

Project Site

PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
N/A	**4041950**	**Acute Care Hospital**	**The Hospital of Central Connecticut**

STREET & NUMBER	
100 Grand Street	
TOWN	**ZIP CODE**
New Britain, Connecticut	**06050**

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
1053477075	**Acute Care Hospital**	**The Hospital of Central Connecticut**

STREET & NUMBER	
100 Grand Street	
TOWN	**ZIP CODE**
New Britain, Connecticut	**06050**

Chief Executive

NAME	TITLE
Lucille Janatka	**Sr. Vice President, Hartford HealthCare and President, Central Region.**

STREET & NUMBER		
100 Grand Street		
TOWN	**STATE**	**ZIP CODE**
New Britain	**CT**	**06050**

TELEPHONE	FAX	E-MAIL ADDRESS
203-694-8202		**lucille.janatka@hhchealth.org**

			Title of Attachment:
Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as	YES NO	**X** ☐	**See Exhibit 1 attached hereto**

the case may be, authorizing the project.		
Does the Applicant have non-profit status? If yes, attach documentation.	YES **X** NO ☐	**See Exhibit 2 attached hereto**
Identify the Applicant's ownership type.	PC ☐ Other: LLC ☐ Corporation **X**	
Applicant's Fiscal Year (mm/dd)	Start **10/01**	End **09/30**

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

NAME		TITLE
Barbara A. Durdy		**Director, Strategic Planning**
STREET & NUMBER		
181 Patricia M. Genova Blvd		
TOWN	STATE	ZIP CODE
Newington	**Connecticut**	**06111**
TELEPHONE	FAX	E-MAIL ADDRESS
860-972-4231	**860-972-9025**	**barbara.durdy@hhchealth.org**
RELATIONSHIP TO APPLICANT	**Employee**	

Identify the person primarily responsible for preparation of the application (optional):

Prepared by			
NAME		TITLE	
Barbara A. Durdy		**Director, Strategic Planning**	
STREET & NUMBER			
181 Patricia M. Genova Blvd			
TOWN	STATE	ZIP CODE	
Newington	**Connecticut**	**06111**	
TELEPHONE	FAX	E-MAIL ADDRESS	
860-972-4231	**860-972-9025**	**barbara.durdy@hhchealth.org**	
RELATIONSHIP TO APPLICANT	**Employee**		

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

The Hospital of Central Connecticut ("HOCC") is proposing to terminate the provision of inpatient and outpatient pediatric services at the New Britain Campus (there are no pediatric services in Southington). The principal reason for termination of inpatient and outpatient pediatric services is a persistent and sustained decline in demand for inpatient and outpatient services by the community, along with the realization that pediatric competencies, quality and efficiencies cannot be maintained without draining other hospital resources for services in significantly greater demand.

This proposal includes the transition of pediatric outpatient clinic services to community pediatric providers, including the Community Health Center, Inc. site located in New Britain d/b/a Community Health Center of New Britain ("CHC-NB"), a federally-qualified health center, and the transition of inpatient pediatric services to the Connecticut Children's Medical Center ("CCMC").

HOCC will ensure that the transition of inpatient and outpatient pediatric services will occur seamlessly for patients and that care coordination and quality are enhanced as part of this proposal. Since the transition will be seamless, there will be no interruption in inpatient or outpatient care or services.

HOCC will continue to provide emergency medical services to pediatric patients in the emergency room and there will be no interruption in the provision of neonatal services in connection with obstetrical services provided on the main hospital campus.

There is no capital cost associated with this proposal.

Due to the very low patient volumes associated with this proposal, patient choice, competition and the diversity of health care providers will not be significantly impacted. Specifically, should OHCA approve this proposal, patients will be provided with a choice of providers to be referred to for their pediatric care.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

Introduction and Background

HOCC is a member of Hartford HealthCare Corporation, an integrated health care delivery system ("HHC"). One of the principal goals of HHC is to deliver high quality, cost-effective, personalized and coordinated care through collaboration with its system members and other community providers. Achieving these goals requires flexibility, coordination, responsible planning and judicious allocation of resources. In the instant case, HOCC proposes to terminate inpatient and outpatient pediatric services and transition these services to other community providers because of demonstrated and sustained declining demand for pediatric inpatient and outpatient pediatric services on the HOCC New Britain campus. More specifically, this proposal involves careful planning and coordination with other community providers for the transition of pediatric outpatient services which are currently being provided in the HOCC pediatric clinic to community pediatricians and CHC-NB, along with the transition of inpatient pediatric services (excluding newborn care associated with HOCC's obstetrical service) to the Connecticut Children's Medical Center ("CCMC").

Inpatient Pediatrics

A steady and sustained decline in utilization of pediatric inpatient services has occurred over the last 20 years, not only in New Britain, Connecticut but throughout the country. Clinical advances in treating vaccine-preventable illnesses, as well as advances in care for conditions such as asthma, diabetes and prematurity has shifted a significant amount of inpatient treatment to the outpatient setting. The majority of children requiring inpatient care are now the most complicated cases often requiring the input of subspecialists and the availability of testing modalities outside the scope of a community-based pediatric inpatient program. Therefore, it is not surprising that HOCC pediatric admissions have steadily declined due to parent or pediatric provider preference and the need for more comprehensive and specialized pediatric services.

See Exhibit 3 attached hereto for copies of the following journal articles supporting the overall trend of decreasing yet more acute and complicated pediatric admissions.

By way of example, the January 2014 HealthCare Cost and Utilization Project (H-CUP) study entitled "Trends in Pediatric and Adult Hospital Stays for Asthma, 2000-2010", found that the rate of pediatric hospital admissions decreased from 165 to 130 per 100,000 population over the

study period. The study concludes that asthma in children is largely controllable with proper primary care. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb169-Asthma-Trends-Hospital-Stays.pdf

The JAMA Pediatrics February 2013 article "Inpatient Growth and Resource Utilization in 28 Children's Hospitals: A Longitudinal, Multi-institutional Study" concludes that between 2004 and 2009, hospitals experienced an increase in the number of children hospitalized with a chronic health condition, in fact, the greatest increase in admissions was attributed to children with a significant chronic health condition affecting 2 or more body systems. This article underscores the fact that inpatients tend to have multiple comorbidities and typically require pediatric specialty and subspecialty expertise. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2962571/

Finally, the article entitled "Children with Complex Chronic Conditions in Inpatient Hospital Settings in the United States" concludes that pediatric admissions, days and charges increased over the 10 year study period for every patient cohort with a diagnosis of one or more complex chronic conditions and that pediatric hospital admissions are associated with attributes consistent with heightened medical complexity. This study furthers supports the need for available inpatient specialty and subspecialty services in order to provide the best possible care for this inpatient pediatric population. http://www.ncbi.nlm.nih.gov/pubmed/23266509

As a result of the overall decrease in pediatric inpatient admissions and the increasing acuity seen nationwide, as a community hospital, HOCC is challenged in maintaining the necessary competencies and specialized services that are commonly available in specialty children's hospitals (e.g., pediatric anesthesia and radiology). In addition, support services, such as child life services and pediatric focused therapists which are integral to the treatment and wellness of children are generally not available outside of specialized children's hospitals.

For the past several years (FY 2010 through FY2014), the inpatient pediatric service at HOCC struggled to maintain an average daily census above 3 patients. In FY 2012, HOCC made a significant financial investment in pediatrics in an attempt to grow a self-sustaining pediatric program by further investing in the pediatric inpatient program. Specifically, in FY 2012, HOCC hired two full time pediatric hospitalists to provide physician coverage for the inpatient unit because community-based pediatricians had indicated that they were no longer interested in following their pediatric patients as inpatients.

However, despite the significant investment in two hospitalist physicians specializing in pediatrics and additional efforts to serve the outpatient pediatric population in New Britain, pediatric admissions continued to decline. In 2014, as a result of the steady decline in pediatric admissions, HOCC made the decision to eliminate the two pediatric hospitalist positions. Since September 2014, there have been no medical pediatric admissions to the inpatient unit by the HOCC community physicians.

Notwithstanding, HOCC currently provides pediatric nursing coverage via an on-call coverage system in the event that a pediatric emergency surgical patient is admitted. The on-call coverage system has been used very infrequently in the past 12 months (i.e. 4 times). Given the low volume of inpatient admissions, maintaining pediatric nursing competencies for nurses taking call is challenging (i.e. only 19 nursing shifts were worked during this period).

Currently, most community physicians direct the HOCC ED to admit their pediatric patients to CCMC. Accordingly, HOCC has made arrangements with CCMC to transfer pediatric patients once they are stabilized to CCMC. See Exhibit 4 attached hereto for the Transfer Agreement and Exhibit 5 attached hereto for Letters of Support from community physicians.

HOCC continues to have an excellent staff of neonatologists, community pediatricians and pediatric physician assistants who provide routine and critical care services to newborns in the Family BirthPlace and in the Neonatal ICU. HOCC remains committed to maintaining and strengthening these neonatal services.

Outpatient Pediatrics

HOCC currently operates an outpatient pediatric clinic located on its New Britain hospital campus. Historically, HOCC has employed two pediatricians to staff its outpatient clinic. In 2015, one of those pediatricians retired. However, because over the past several years, the number of patients served by the HOCC outpatient clinic has decreased, HOCC did not hire a second pediatrician to staff the outpatient clinic. Currently, the HOCC outpatient clinic is staffed by one full-time employed pediatrician. The one full-time pediatrician currently has a panel size of approximately 1,200 patients with annual visits projected at 3,500. The size of the outpatient pediatric practice in the outpatient clinic does not justify the continuation of one full time pediatrician and the pediatrician is not interested in staying on a part-time basis. Under these circumstances, appropriate clinical coverage during evenings, nights and weekends is difficult to manage for the patients of the clinic with one pediatrician. In addition, pediatric patient not only require routine pediatric medical care, but they also require ancillary services such as, behavioral health, and dentistry that are unavailable at HOCC. Moreover, the HOCC pediatric clinic does not provide expanded hours of operations or evening and weekend coverage. Again, HOCC attempted to secure after-hours coverage (i.e. evenings, nights and weekends) from community providers, but was unsuccessful. Therefore, pediatric patients who require medical attention outside of normal clinic hours of operation are currently assisted by a nurse triage line, and as needed, directed to the HOCC ED.

If this proposal is approved, HOCC pediatric clinic patients will be able to choose to transition their care to either CHC-NB or to community pediatricians who have available capacity. See Exhibit 5 attached hereto. Subject to OHCA approval, pediatric patients will be notified of the plan to transition their care to the provider of their choice. In fact, the remaining employed physician provider currently staffing the HOCC outpatient clinic is planning on a private practice in the New Britain community and has indicated her willingness to accept these patients should she open a practice.

Please see Exhibit 6 attached hereto for a copy of the Transition Plan for outpatient pediatric services at HOCC.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

As discussed in the background provided above, despite significant investments made by HOCC in 2012 to enhance inpatient pediatric services at HOCC, patient volume continued to decline. Without adequate demand to support the service and utilize the services, the services are no longer sustainable.

Discussion with CCMC began in early FY 2015 to update the Transfer Agreement between HOCC and CCMC and to develop a plan to transition all inpatient medical pediatric admissions directly to CCMC.

Please see Exhibit 4 attached hereto for a copy of the Transfer Agreement between CCMC and

HOCC.

At the same time, discussions began at HOCC to consider the transition of outpatient pediatric clinic patients to community providers minimizing the disruption to patients while enhancing the level of services available to the pediatric patient population in the community. CHC-NB and community pediatricians were contacted to get their input and to gauge their interest in and ability to accept new patients. In addition to CHC-NB, many pediatricians in the community indicated that they have available capacity to accept the HOCC pediatric outpatients as part of the HOCC Transition Plan. See Exhibit 5 attached hereto.

3. Provide the following information:

   a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

      Please see OHCA Table 1 below.

   b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

      Please see OHCA Table 2 below.

4. List the health care facility license(s) that will be needed to implement the proposal;

   There will be no change in licensure as a result of this proposal.

5. Submit the following information as attachments to the application:

   a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

      Please see Exhibit 7 attached hereto for a copy of HOCC's hospital license issued by the State of Connecticut Department of Public Health.

   b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

      Please see Exhibit 8 attached hereto for copies of the curriculum vitae of key professional, administrative, clinical and direct service personnel related to the proposal.

   c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

      N/A. No new services are being proposed.

   d. letters of support for the proposal;

      Please see Exhibit 5 attached hereto for letters of support related to this proposal.

e. The protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

N/A. No new services are being proposed.

f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Please Exhibit 4 attached hereto for a copy of the Transfer Agreement between HOCC and CCMC.

Public Need and Access to Care

§ "Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

This proposal is consistent with policies and standards set forth in Connecticut General Statute Section 19a-639(a)(1) in that the proposed termination of pediatric services will be subject to OHCA's prior approval. In addition, the proposal to terminate inpatient and outpatient pediatric services is based on the need to allocate HOCC's limited resources in the most cost-effective manner and avoid an unnecessary duplication of services.

§ "The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

This project aligns with the Statewide Health Care Facilities and Services Plan by ensuring that cost-effective pediatric services are provided and that the New Britain community has continued and enhanced access to pediatric health care services in a more efficient and better coordinated manner. Moreover, consistent with the Statewide Health Care Facilities and Services Plan, HOCC recognizes that it would be duplicative and a poor use of limited resources to continue to provide an underutilized and duplicative service.

§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))

8. With respect to the proposal, provide evidence and documentation to support clear public need:

a. identify the target patient population to be served;

The patient population served are pediatric patients that originate from the greater New Britain community.

b. discuss how the target patient population is currently being served;

Currently, non-newborn medical pediatric patients who require inpatient admission are transferred to CCMC via ambulance from the HOCC emergency department. As discussed above, the community pediatricians have opted not to admit their pediatric patients to HOCC without hospitalist coverage. When inpatient hospitalist coverage was provided there was an inadequate number of admissions from the pediatricians in the community to sustain the staffing because many of the patients were being admitted to CCMC. Pediatric patients who require outpatient pediatric services are seen in the HOCC outpatient pediatric clinic located on the New Britain hospital campus. However, as discussed earlier, there are an inadequate number of patients to support two FTE outpatient pediatricians and even with one physician, there is no evening and weekend coverage and the practice is at only 50% capacity.

c. document the need for the equipment and/or service in the community;

N/A. No new services are being proposed.

d. explain why the location of the facility or service was chosen;

N/A. No new services are being proposed.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

N/A. No new services are being proposed.

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

Pediatric patients requiring inpatient care, including underserved populations, will benefit by receiving their inpatient care at CCMC which offers the full array of specialty, subspecialty and ancillary pediatric services.

Pediatric clinic patients, many whom are underserved, will benefit by transitioning their care to community providers, including CHC, which offers a more complete array of ambulatory services for children and who are better positioned to more effectively coordinate the care required on a 24/7, 365 day-per-year thereby reducing the incidence of inappropriate ED visits.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

This proposal is for the termination of inpatient and outpatient pediatric services at HOCC. The change was necessary because there is no longer adequate demand to support the level of service that is needed to provide the highest quality, most cost-effective pediatric inpatient and outpatient services. Please see the Project Description above for a complete

and detailed response for why the change is necessary.

h. explain how access to care will be affected;

HOCC has developed a detailed Transition Plan for inpatient and outpatient pediatric services to ensure that there will be no interruption in care or services resulting from this proposal. See Exhibit 6 attached hereto. Specifically, inpatient pediatric care will be provided by CCMC and outpatient pediatric services will be provided by local community providers. Both CCMC, CHC-NB, and community-based pediatric practices are better positioned to provide 24/7, 365 days-per-year advanced and coordinated care for children in the New Britain community. Access to pediatric care will not be negatively affected because only a relatively small number of patients use the HOCC service and those services will continue to be provided in the community by other community providers.

i. discuss any alternative proposals that were considered.

As discussed earlier in this application, HOCC made a significant effort and financial investment to develop and enhance pediatric services, but despite HOCC's' best efforts and significant investment, pediatric volume continued to decline and the service could not sustain itself.

This proposal reflects HOCC's determination that in order to provide the highest quality and most cost-effective pediatric services to the community, other providers are better suited to provide, manage and coordinate the care.

§ "Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;" (Conn.Gen.Stat. § 19a-639(a)(5))

9. Describe how the proposal will:

a. improve the quality of health care in the region;

As discussed in the response to Question #8f above, all patients, including Medicaid patients, will transition to community providers such as CCMC and CHC and community pediatricians where they will have expanded access to services and better coordinated care on a 24/7, 365 days-per-year basis.

b. improve accessibility of health care in the region; and

As discussed in the response to Question #8f above, all patients, including Medicaid patients, will benefit by having access to enhanced, better coordinated services offered by CCMC, community physicians' and CHC-NB on a 24/7, 365 days-per-year basis, a level of service which HOCC was challenged to provide.

c. improve the cost effectiveness of health care delivery in the region.

The transition of inpatient services to CCMC will eliminate underutilized and duplicative services at HOCC and will result in cost savings by offering a more cost-effective means of delivering inpatient pediatric services.

To the extent that outpatient services are transitioned to CHC-NB, enhanced coordination and elimination of duplicative and underutilized services will result in a more cost-effective model for delivering outpatient pediatric services to the greater New Britain community.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

The coordination of inpatient care will be greatly facilitated as a result of the breadth and depth of pediatric specialty, subspecialty and ancillary services offered by CCMC at its main campus. It is expected that CCMC will refer the pediatric inpatients back to their community providers upon discharge.

To the extent that outpatient services will be transitioned to CHC-NB and community pediatricians, care coordination will be greatly enhanced through improved access to health care services on evenings and weekends. In addition, inappropriate ED utilization will be reduced for those patients who are currently receiving their care at the HOCC outpatient clinic when there is no evening and weekend coverage.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

As discussed in the response to Question #8f above, all patients, including Medicaid patients, will benefit by having access to high-quality pediatric services 24/7, 365 days-per-year as they transition to community providers such as CCMC and CHC-NB and community pediatricians.

> *§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

See Exhibit 9 for HHC's Financial Assistance Policy.

13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

N/A. This proposal will not reduce access to services for Medicaid patients.

> *§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health*

care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))

14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

It is not anticipated that this proposal will adversely affect patient health care costs. The impact on patient health care costs will be positive resulting from less duplication and underutilization of services, improved care coordination and avoidance of unnecessary ED visits.

Financial Information

§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the application," (Conn.Gen.Stat. § 19a-639(a)(4))

15. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

As previously mentioned in the application, this proposal is cost-effective as it reduces duplicative services and avoids costs related to health care services that are underutilized. In addition, this proposal will reduce costly and inappropriate emergency department visits by aligning pediatric patients with providers that provide 24/7, 365 days-per-year coverage.

16. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3.**

Please see OHCA Table 3. There are no capital costs associated with this project.

17. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Please see OHCA Table 3. There are no capital costs associated with this project.

18. Include as an attachment:

a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books.). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

FY 2014 audited financial statements for HOCC are on file with OHCA.

b. completed **Financial Worksheet A (not-for-profit entity), B (for-profit entity) or C (§19a-486a sale)** available on OHCA's website under OHCA Forms, providing a

summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

Please see Exhibit 10 attached hereto for Financial Worksheet A.

19. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

    Please see OHCA Table 4.

20. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

    FY 2014 Baseline Assumptions:

    - **Inpatient volume projected to decrease 5.6% into FY2016 and remain constant through FY 2019**
    - **Outpatient volume projected to increase 2% into FY 2016 and 1% each year after.**
    - **Less than 1% increase year over year- Incraese in government payor mix and offsetting decrease in non-government payors.**
    - **Increases in other operating revenues from grants, joint ventures and services to other affiliates.**
    - **Salary increase of 2% and maintaining staffing levels at 1788 FTE's.**
    - **Other non-salary related inflationary increases.**

21. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

    N/A. This proposal is for termination of pediatric inpatient and outpatient services. There will be no losses from termination of the services, provided, however, there will be positive financial impact by virtue of eliminating losses associated with the pediatric service resulting in a net positive impact on the HOCC financial performance.

22. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

    N/A. This proposal is for termination of inpatient and outpatient pediatric services.

Utilization

§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))

23. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

    Please see OHCA Tables 5 and 6.

24. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Tables 5 and 6.

    N/A. This proposal is for termination of inpatient and outpatient pediatric services.

25. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

    Please See OHCA Table 7.

§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))

26. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

    For purposes of this proposal, the population is defined as pediatric medical inpatients and pediatric clinic outpatients ages 6 months to 17 residing in the greater New Britain community.

27. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

    Please see OHCA Table 8.

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))

28. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnotes), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

    Please see OHCA Table 9.

29. Describe the effect of the proposal on these existing providers.

    To the extent that community providers have open panels and have capacity to accept new patients, HOCC will facilitate the transition of pediatric clinic patients to these providers.

    Please see letters from community pediatricians with open panels agreeing to accept new patients attached hereto as Exhibit 5 attached hereto.

30. Describe the existing referral patterns in the area served by the proposal.

    Referrals patterns to community pediatricians come from a variety of sources, including friends and family members, as well as from pediatric specialists, and in the case of newborns, from HOCC.

31. Explain how current referral patterns will be affected by the proposal.

    If the proposal is approved by OHCA, HOCC will notify all existing clinic patients and families that HOCC will no longer be providing outpatient clinic services and will facilitate the transition of care to a community pediatrician or the CHC-NB.

    As previously mentioned, HOCC will still continue to provide obstetrical and neonatal services on its New Britain campus.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

32. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

    N/A. This proposal is for termination of services. By approving HOCC's request to terminate the provision of inpatient and outpatient pediatric services, OHCA will permit HOCC to discontinue the underutilization of duplicative inpatient and outpatient pediatric services.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. . ." (Conn.Gen.Stat. § 19a-639(a)(11))*

33. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region?.

This proposal is for the termination of underutilized pediatric services which can more effectively be provided by community pediatricians, CHC-NB and CCMC.

Due to the very low patient volumes associated with this proposal, patient choice, competition and the diversity of health care providers will not be significantly impacted. Patients will continue to have a variety of choices with respect to where they receive their pediatric services and thus, will have a diversity of health care providers to choose from.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Inpatient Medical Pediatric Services	The Hospital of Central Connecticut 100 Grand Street New Britain , CT 06050	New Britain Southington Berlin Newington Plainville	7 Days/Week 24/7 No admissions by community physicians	Inpatient Medical Pediatric Services
Outpatient Pediatric Clinic services	The Hospital of Central Connecticut 100 Grand Street New Britain , CT 06050	New Britain Southington Berlin Newington Plainville	Monday through Friday 8am to 5pm Staffed by one pediatrician	Outpatient Pediatric Clinic services

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TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Primary Service Area New Britain Southington Berlin Newington Plainville	Primary Service area towns represent those towns from where 80% of inpatient discharges originate

* Village or place names are not acceptable.

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TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging) Land/Building Purchase* Construction/Renovation** Land/Building Purchase* Other (specify)	N/A
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical Imaging)***	
Total Capital Cost (TCO)	
Total Project Cost (TCE+TCO)	

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

N/A. There is no capital expenditure related to this proposal.

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TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016*	FY 2017*	FY 2018*
Revenue from Operations	($212,669.00)	($212,669.00)	($212,669)
Total Operating Expenses	($1,083,601.00)	($1,106,641.00)	($1,134,250.00)
Gain/Loss from Operations	($870,932.00)	$893,972.00	$921,582.00

* Fill in years using those reported in the Financial Worksheet attached.

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TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			Annualized FY 2015 Volume*
	FY 2012***	FY 2013***	FY 2014***	FY 2015***
Inpatient Pediatric Discharges	191	237	135	0
Outpatient Pediatric Clinic Visits	5070	5593*	5344	3,500
Total	5261	5830	5479	3,500

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.

** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

FY 2015 volume data is for 9months October 2014 through June 2015.

***Note: For a brief period of time during FY 2013 the HOCC Chief of Pediatrics also treated patients in the outpatient clinic which contributed to the small spike in patient volume during FY 2013.**

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TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2016**	FY 2017**	FY 2018**
Inpatient Pediatric Discharges	N/A	N/A	N/A
Outpatient Pediatric Clinic Visits	N/A	N/A	N/A
Total			

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

N/A. This proposal is for a service termination.

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TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2014**		Projected					
			FY 2015**		FY 2016**		FY 2017**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	7089	45.9	7008	45.5	7008	45.5	7008	45.5
Medicaid*	4161	26.2	3939	26.7	3939	26.7	3939	26.7
CHAMPUS & TriCare	19	-	18	.1	18	.1	18	.1
Total Government	**11269**	**72.1**	**10965**	**72.3**	**10965**	**72.3**	**10965**	**72.3**
Commercial Insurers	4099	26.2	3893	26.4	3893	26.4	3893	26.4
Uninsured	224	1.4	151	1.0	151	1.0	151	1.0
Workers Compensation	48	.3	41	.3	41	.3	41	.3
Total Non-Government	**4371**	**27.9**	**4085**	**27.7**	**4085**	**27.7**	**4085**	**27.7**
Total Payer Mix	**15640**	**100**	**14750**	**100**	**14750**	**100**	**14750**	**100**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

The payer mix presented in Table 7 above represents all inpatient discharges at HOCC for the time periods indicated. The projected increase in Medicaid reflects a shift from uninsured to Medicaid due to coverage expansion.

[back to question]

TABLE 8
UTILIZATION BY TOWN

Inpatient Pediatric Discharges	
Town	**Utilization FY 2014**
Bristol	**3**
Farmington	**1**
Berlin	**6**
New Britain	**92**
Plainville	**6**
Windsor	**1**
Newington	**2**
Meriden	**3**
Plantsville	**2**
Southington	**10**
Waterbury	**3**
Wolcott	**3**
Naugatuck	**1**
Thomaston	**1**
Indian Head, MD	**1**
	135

Approximately 82% of all inpatient discharges originate from the primary services area towns presented above in Table 2.

Outpatient Pediatric Visits	
Town	Utilization FY 2014
Allingtown- CT	2
Barry Square- CT	45
Berlin- CT	35
Bishop's Corner- CT	5
Bloomfield- CT	4
Blue Hills- CT	21
Bristol- CT	182
Buckland- CT	7
Burlington- CT	10
Central- CT	2
Corbins Corner- CT	9
Daytona Beach- FL	1
East End- CT	8
East Hartford- CT	19
Elmwood- CT	4
Farmington- CT	3
Gurleyville- CT	1
Hartford- CT	146
Meriden- CT	51
Middletown- CT	17
Naugatuck- CT	5
New Britain- CT	4574
New Haven- CT	5
Newbury- VT	1
Philadelphia- PA	3
Plainville- CT	71
Plantsville- CT	7
Plaza- CT	7
Portland- CT	2
Rocky Hill- CT	5
Simbury- CT	2
Simsbury- CT	3
Southington- CT	32
Suffield- CT	11
Wallingford- CT	9
Waterbury- CT	17
Wilson- CT	18
	5344

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in year if the time period reported is not *identical* to the fiscal year reported on pg. 2 of the application; provide the date range using the mm/dd format as a footnote to the table.

Approximately 89% of all outpatient visits originate from the primary services area towns presented above in Table 2.

ack to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
Outpatient Pediatric Clinic	New Britain, CT	1710983937 1013939867 1598864217	Community Health Center 85 Lafayette Street New Britain, CT 06051` Multiple providers	M-Th: 8:00 AM -6:30 PM Friday: 8:00 AM -5:00 PM Saturday: 8:00 AM – 4:00 PM	Unknown
Community Pediatricians	New Britain, CT	1386694750	Phillips Foster, MD 40 Hart Street New Britain, CT 06051	M, T, Th: 9:00 AM -3:00 PM	Unknown
		1316943285	Grove Hill Medical Center 300 Kensington Avenue New Britain, CT 06051 184 East Street Plainville, CT 06062 Multiple providers	M-F: 8:30 AM -5:00 PM Weekend by appointment M-F: 9:00 AM -4:30 PM Weekend by appointment	Unknown
		Unknown	New Britain Pediatric Group 1095 West Main Street New Britain, CT 06053 Multiple providers	M-F: 9:00 AM -4:30 PM	Unknown
		1588699235	Personal Care Pediatrics 340 North Main Street Southington, CT 06489		Unknown
		1528120094	Pediatric Care Center 780 Farmington Ave Bristol, CT 06010		Unknown
		1811994007	Berlin Pediatric Associates 742 Worthington Rd Suite A Berlin, CT 06037		Unknown
		1467519793	Mark Peterson, MD 143 North Main Street		Unknown

			Southington,CT 06489		
		1649286766	**Alpa Patel, MD** **710 Main Street, Building 1** **Plantsville, CT 06479**		**Unknown**
		1184647380	**George Skarvinko, MD** **Southington Pediatric Associates** **209 Main Street Suite A** **Southington,CT 06489**		**Unknown**
		1760579296	**Teresa M. Szajda, MD** **7 North Washington Street, Suite 109** **Plainville, CT 06062**		**Unknown**

*** Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provide**r Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

Supplemental CON Application Form

Termination of a Service

Conn. Gen. Stat. § 19a-638(a)(5),(7),(8),(15)

Applicant: The Hospital of Central Connecticut

Project Name: Termination of Inpatient and Outpatient Pediatric Services

Affidavit

Applicant: The Hospital of Central Connecticut

Project Title: Termination of Inpatient and Outpatient Pediatric Services

I, **Lucille Janatka, Sr. Vice President Hartford HealthCare and President of Hartford HealthCare Central Region**
(Name) (Position – CEO or CFO)

of **The Hospital of Central Connecticut** being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 8/24/15

Subscribed and sworn to before me on 8/24/15

_____
Notary Public/Commissioner of Superior Court

My Commission Expires March 31, 2016

My commission expires: _____

1. Project Description: Service Termination

   a. Please provide:

      i. a description of the history of the services proposed for termination, including when they commenced,

      HOCC has a long history of providing inpatient and outpatient pediatric services to the greater New Britain community. As discussed in detail in the CON main application, a decrease in utilization of pediatric inpatient services has occurred over the last 20 years, not only in New Britain, Connecticut but throughout the country. Clinical victories in treating vaccine-preventable illnesses as well as advances in care for conditions such as asthma, diabetes and prematurity have shifted many of the treatment options to the outpatient arena. The majority of children requiring inpatient care are now the most complicated cases often requiring the input of subspecialists and availability of testing modalities outside the scope of a community pediatric inpatient program. Therefore, it is not surprising that pediatric admissions have steadily declined due to parent or provider preference and the need for more comprehensive and specialized services. As a result of the dramatic decrease in volume seen nationwide, community hospitals are unable to provide the ancillary services available in a tertiary care children's hospital such as child life services and pediatric focused therapists. In a community hospital setting, it has become a challenge to maintain the nursing skill set for pediatrics that hospitalized children deserve.

      The number of clinic outpatients served as well as the number of pediatricians available to care for those patients has decreased. In addition, the health status of the community served by HOCC implies a need for routine pediatric medical care plus coordinated supportive ancillary services that are not available in the HOCC outpatient clinic such as behavioral health, school based services, and dentistry.

      Patient volume at the HOCC pediatric clinic is insufficient to warrant staffing with more than one physician provider. Under these circumstances, appropriate clinical coverage (evenings, nights and weekends) cannot be adequately provided. Pediatric patients who require medical attention outside of normal clinic hours of operation are directed to the HOCC emergency department for care.

      ii. whether CON authorization was received and,

      CON authorization specific to inpatient and outpatient pediatric services was not necessary to establish these services.

      iii. if CON authorization was required, the docket number for that approval.

      N/A. CON authorization was not necessary.

   b. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.

Please see main CON application for detailed rationale for this service termination.

HOCC's executive and clinical leadership continually evaluates the clinical efficacy of all programs and services offered. As part of this review, programs that are not fully utilized and are not meeting the highest patient service standards are identified for potential elimination. Due to declining volumes and difficulty maintaining staff competencies, inpatient and outpatient pediatric services have been identified for transition to community providers who are better positioned to coordinate the care of these patients.

c. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted on.

Yes, the HOCC Board of Directors approved this proposal to terminate inpatient and outpatient pediatric services on May 6, 2015. Please see Exhibit 1 attached hereto for a copy of the Board resolution authorizing this CON application.

2. Termination's Impact on Patients and Provider Community

a. For each provider to which the Applicant proposes transferring or referring clients, provide the below information for the last completed fiscal year and current fiscal year.

TABLE A
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Facility Name	Facility ID*	Facility Address	Total Capacity	Available Capacity	Utilization FY XX**	Utilization Current CFY***
Connecticut Children's Medical Center	Unknown	282 Washington St, Hartford, CT 06106	115 Licensed Beds	115 Available Beds	Unknown	Unknown
Community Health Center-NB	1710983937 1013939867 1598864217	85 Lafayette Street New Britain, CT 06051`	Unknown	Unknown	Unknown	Unknown
Personal Care Pediatrics Arthur Blumer, MD	1588699235	340 North Main Street Southington, CT 06489	Unknown	Unknown	Unknown	Unknown
Pediatric Care Center Susan Adeife-Adenyinka, MD	1528120094	780 Farmington Avenue Bristol, CT	Unknown	Unknown	Unknown	Unknown
Berlin Pediatric Associates Matteo Loprieato,MD	1811994007	742 Worthington Rdge #A Berlin,CT 06037	Unknown	Unknown	Unknown	Unknown

Grove Hill Medical Center Angela Geddis, MD	**1316943285**	**300 Kensington Avenue,#1 New Britain, CT 06051 184 East Street Plainville , CT 06062**	**Unknown**	**Unknown**	**Unknown**	**Unknown**
Mark Peterson, MD	**1467519793**	**143 North Main Street Southington, CT 06489**	**Unknown**	**Unknown**	**Unknown**	**Unknown**
Alpa Patel, MD	**1649286766**	**710 Main Street, #1 Plantsville, CT 06479**	**Unknown**	**Unknown**	**Unknown**	**Unknown**
Foster Phillips, MD	**1386694750**	**40 Hart Street #C1 New Britain, CT 06052**	**Unknown**	**Unknown**	**Unknown**	**Unknown**
Southington Pediatric Associates George Skarvinko, MD	**1184647380**	**209 Main Street, A Southington, CT 06489**	**Unknown**	**Unknown**	**Unknown**	**Unknown**
Teresa Szajda, MD	**1760579296**	**7 North Washington Street, #109 Plainville, CT 06062**	**Unknown**	**Unknown**	**Unknown**	**Unknown**

* Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

** Fill in year and identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

b. Provide evidence (e.g., written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.

Please see Exhibit 5 attached hereto for letters from community providers who have capacity to absorb these patients and have expressed a willingness to do so.

c. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for Medicaid recipients and indigent persons.

N/A. There are no special populations utilizing these services.

This proposal will enhance services and coordination of care for Medicaid patients by transitioning their care to community providers who offer a broader array of pediatric services than can be provided at HOCC.

d. Describe how clients will be notified about the termination and transfer to other providers.

All patients who have received care at the HOCC outpatient clinic will receive written information about alternative providers in the community including community pediatricians and CHC. HOCC will facilitate the transition of these patients to the most clinically appropriate community provider. In addition, upon approval from OHCA, clinicians will discuss the transition plan with each patient during clinic visits. There will also be kiosks that will allow patients to review the choice of providers and plan for transition.

e. For DMHAS-funded programs only, attach a report that provides the following information for the last three full FYs and the current FY to-date:
   i. Average daily census;
   ii. Number of clients on the last day of the month;
   iii. Number of clients admitted during the month; and
   iv. Number of clients discharged during the month.

N/A. This proposal is not for a DMHAS program.

Exhibit 1

The Hospital of Central Connecticut

MEETING OF THE BOARD OF DIRECTORS

May 6, 2015

Minutes

PRESENT: Letterio Asciuto MD, Marie S. Gustin, Joseph Harrison MD, Jason Howey, Lucille Janatka, Frank R. Miller, Akella Sarma MD, Joseph Voelker, William W. Weber, Lindsley Wellman; also attending Carolyn Freiheit, Steven D. Hanks MD, Nancy Kroeber, Cathy Stevens and Joann Willette

ABSENT: Denise McNair, George C. Springer Jr.

GUESTS: James Blazar, Jeffrey Flaks, Rocco Orlando MD

1. **Call to Order**: Joseph Voelker, Chairman of the Board, called the meeting to order at 8:00 a.m. in Conference Rooms B and C at the Hartford HealthCare Cancer Institute at The Hospital of Central Connecticut.

2. **Recognition**: Lucille Janatka, Central Region President, expressed her appreciation to the Board members for their leadership and contributions as a director of The Hospital of Central Connecticut Board as well as their service to various hospital Board committees. Ms. Janatka mentioned to the Board that even though their role may be changing with the establishment of the new Regional Boards, she encouraged them to stay engaged with Hartford HealthCare.

5. **Consent Agenda:** Mr. Voelker requested approval of items listed on the consent agenda.

   Action A motion was made, seconded, and it was voted to approve:

   - Minutes of the Board of Directors Meeting – March 4, 2015
   - Minutes of the Quality & Credentialing Committee Meeting – February 20, 2015
   - Financial Report

6. **Resolutions**:

- Termination of Inpatient and Outpatient Pediatric Services at The Hospital of Central Connecticut: Lucille Janatka reported that The Hospital of Central Connecticut is preparing to submit a Certificate of Need (CON) application for the termination of inpatient and outpatient pediatric services at the New Britain campus. HOCC will continue to provide obstetrical and neonatal services to the community. The proposal involves the transition of pediatric outpatient services to Community Health Center Association of Connecticut and the transition of inpatient pediatric services to the Connecticut Children's Medical Center.

  Mr. Weber mentioned that HOCC management should contact key state representatives to inform them of the termination of these services.

  Action A motion was made, seconded, and it was voted to approve the Resolution for the Termination of Inpatient and Outpatient Pediatric Services at The Hospital of Central Connecticut.

Copies of both Resolutions are attached to the permanent minutes.

12. **Other Business:**

    1. A list of the planned events for the Grand Opening of the Cancer Center is included in the meeting material.
    2. Mr. Voelker mentioned that a tour of the Cancer Center would be available after the meeting if anyone was interested.
    3. Mr. Voelker reminded the members that the Board Reception for HOCC and HHC Senior Care Services will be held on July 8th at the Southington Care Center.
    4. Today, May 6, 2015 is the last meeting of the current HOCC Board of Directors.

13. **Adjournment:** There being no further business, it was motioned, seconded and passed to adjourn the meeting at 10:15 a.m.

William W. Weber

William W. Weber
Secretary

jw

Exhibit 2

Internal Revenue Service
Director, Exempt Organizations

Date:
JUN 26 2007

The Hospital of Central Connecticut
at New Britain General and
Bradley Memorial
100 Grand Street
New Britain, CT 06050

Department of the Treasury
P.O. Box 2508
Cincinnati, Ohio 45201

Person to Contact - ID#:
Gwen Shaw - 75078
Contact Telephone Numbers:
877-829-5500 Phone
513-263-3756 FAX
Federal Identification Number:
06-0646768

Dear Sir or Madam:

By our determination dated January, 1937, you were held to be exempt from Federal Income Tax under the provisions of section 501(c)(3) of the Internal Revenue Code.

You recently furnished us information that New Britain General Hospital merged with Bradley Memorial Hospital and Health Center Inc on October 1, 2006. New Britain General Hospital which was the surviving organization changed it name to The Hospital of Central Connecticut at New Britain General and Bradley Memorial. Based on the information submitted, we have determined that the merger does not affect your exempt status. The organization will continue using Employer Identification Number 06-0646768.

Please let us know about any further changes in the character, purposes, method of operation, name or address of your organization.

If you have any questions regarding this matter, please contact the person whose name and telephone number appear in the heading of this letter.

Sincerely,

Robert Choi
Director, Exempt Organizations
Rulings and Agreements

Exhibit 3

Pediatrics. Author manuscript; available in PMC 2010 Oct 22.
Published in final edited form as:
Pediatrics. 2010 Oct; 126(4): 647–655.
Published online 2010 Sep 20. doi: 10.1542/peds.2009-3266

PMCID: PMC2962571
NIHMSID: NIHMS238735

Children With Complex Chronic Conditions in Inpatient Hospital Settings in the United States

Tamara D. Simon, MD, MSPH,[a] Jay Berry, MD, MPH,[b] Chris Feudtner, MD, PhD, MPH,[c] Bryan L. Stone, MD,[a] Xiaoming Sheng, PhD,[d] Susan L. Bratton, MD, MPH,[e] J. Michael Dean, MD, MBA,[e] and Rajendu Srivastava, MD, MPH[a]

[a]Division of Inpatient Medicine, Department of Pediatrics, University of Utah, Salt Lake City, Utah
[b]Division of General Pediatrics, Children's Hospital Boston, Boston, Harvard Medical School, Boston, Massachusetts
[c]Division of General Pediatrics, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania
[d]Pediatric Research Enterprise, Department of Pediatrics, University of Utah, Salt Lake City, Utah
[e]Division of Critical Care, Department of Pediatrics, University of Utah, Salt Lake City, Utah
Address correspondence to Tamara D. Simon, MD, MSPH, University of Washington, Department of Pediatrics, Division of Hospital Medicine, Seattle Children's Research Institute, Building 1, M/S C9S-5, 1900 9th Ave, Seattle, WA 98101. Email: tamara.simon@seattlechildrens.org

Abstract

Go to:

OBJECTIVES

Hospitalized children are perceived to be increasingly medically complex, but no such trend has been documented. The objective of this study was to determine whether the proportion of pediatric inpatient use that is attributable to patients with a diagnosis of one or more complex chronic condition (CCC) has increased over time and to assess the degree to which CCC hospitalizations are associated with attributes that are consistent with heightened medical complexity.

METHODS

A retrospective observational study that used the 1997, 2000, 2003, and 2006 Kids Inpatient Databases examined US hospitalizations for children. Attributes of medical complexity included hospital admissions, length of stay, total charges, technology-assistance procedures, and mortality risk.

RESULTS

The proportion of inpatient pediatric admissions, days, and charges increased from 1997 to 2006 for any CCC and for every CCC group except hematology. CCCs accounted for 8.9% of US pediatric admissions in 1997 and 10.1% of admissions in 2006. These admissions used 22.7% to 26.1% of pediatric hospital days, used 37.1% to 40.6% of pediatric hospital charges, accounted for 41.9% to 43.2% of deaths, and (for 2006) used 73% to 92% of different forms of technology-assistance procedures. As the number of CCCs for a given admission increased, all markers of use increased.

CONCLUSIONS

CCC-associated hospitalizations compose an increasing proportion of inpatient care and resource use. Future research should seek to improve methods to identify the population of medically complex children, monitor their increasing inpatient use, and assess whether current systems of care are meeting their needs.

Keywords: child health services, health care delivery/access, health services research, hospitalization, children with special needs

Children with special health care needs (CSHCN), defined as children who have or at risk for a chronic physical, developmental, behavioral, or emotional condition and require health and related services of a type or an amount beyond that required by children generally, constitute 18% (~12.6 million) of US children.[1] The Institute of Medicine has identified CSHCN as a priority population,[2] in part because of their use of health resources. A small proportion of children account for the bulk of health care expenditures in the United States: 20% of children who use medical services account for ~80% of all children's health care expenditures.[3]

Chronic illness accounts for the majority of children's hospital days and dollars.[4] A smaller set of CSHCN, termed medically complex children, are perceived to use a disproportionate amount of resources, particularly in the inpatient and tertiary care settings.[5] Consistent and complete identification criteria of this subpopulation for administrative, clinical, and research purposes, however, remains elusive.[5–7] A prototypical medically complex child has a diversity of conditions and multisystem disease; may be technology-dependent; has frequent inpatient admissions; and requires multiple medications, multiple subspecialists, and optimal care coordination across inpatient and outpatient settings.[5] Previous work describing the 6.5% of children with disabilities,[8,9] the nearly 5% of children with multiple chronic conditions,[10] or children with technology dependence[5] likely described sets of children with some degree of medical complexity.

For accurate attribution of health care use of medically complex children, an operational definition is needed for use in administrative data sets. One potential method to study medically complex children is to group International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes so as to specify a set of complex chronic conditions (CCCs). Developed initially for the purpose of identifying children who are at risk for death,[11–15] the working definition for a CCC was "any medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or 1 system severely enough to require specialty pediatric care and probably some period of hospitalization in a tertiary care center."[11] Although CCCs likely do not capture all medically complex children, the definition and implementation of the CCC scheme incorporates 3 hallmarks of medical complexity: chronic medical conditions, often existing in comorbid combinations, and associated with intensive inpatient use. In this study, we sought to determine whether the proportion of pediatric inpatient use for CCCs increased over time from 1997 to 2006 and to assess the degree to which hospitalizations of patients with CCCs were associated with use of inpatient health care resources and outcomes consistent with heightened medical complexity.

METHODS

Go to:

Study Design and Setting

We conducted a retrospective observational study by using longitudinal panel data from the 1997, 2000, 2003, and 2006 Healthcare Cost and Utilization Project Kids Inpatient Databases (HCUP KID). HCUP KID includes nationally representative hospital discharges for children on the basis of a random 80% sample of pediatric discharges and 10% of uncomplicated births. Each data set includes weighted discharges (6.657, 7.291, 7.409, and 7.559 million, respectively) from hospitals (2521, 2784, 3438, and 3739, respectively) across various states (22, 27, 36, and 38, respectively). The HCUP KID sampling frame changed over time; the addition of more states and hospitals in later years and exclusion of short-term rehabilitation hospitals after 1997 has led to a more representative sample.[16] The HCUP KID data set contains publicly available deidentified data. The study was reviewed and deemed exempt from review by the institutional review board at the University of Utah.

Study Population

We analyzed all hospitalizations for children who were aged 0 to 18 years for consistency during the study period.[16]

Measured Attributes of Medical Complexity

We examined both proportions and total numbers of pediatric hospital admissions, length of stay (LOS), total charges, technology-assistance procedures,[5,17] and mortality.[13] Technology-assistance procedures were defined by using ICD-9-CM procedure codes for gastrostomy (43.1), permanent tracheostomy (31.2×), and extracranial ventricular shunt (02.3×). The use of these procedure codes alone does not distinguish between first-time placement and replacement of devices[18] but identifies hospitalizations in which devices were placed.

Main Predictor Variables

All pediatric hospitalizations were classified both by CCC category by using ICD-9-CM diagnosis codes and by CCC category count (0, 1, and multiple consisting of admissions with ≥2 CCC categories).[11] Hospitalizations were classified by CCC count to provide detail about increasing complexity. CCC categories are neuromuscular (eg, brain and spinal cord malformations, mental retardation, central nervous system degeneration and disease, infantile cerebral palsy, epilepsy, muscular dystrophies and myopathies), cardiovascular (eg, heart and great vessel malformations, cardiomyopathies, conduction disorders, dysrhythmias), respiratory (eg, respiratory malformations, chronic respiratory disease, cystic fibrosis), renal, gastrointestinal, hematology and immunodeficiency, metabolic, other congenital or genetic defect (eg, chromosomal abnormalities, bone and joint abnormalities, diaphragm and abdominal wall), and malignancy.[11] Although there were changes in ICD-9-CM diagnosis and procedure codes during the study period, none that changed either measured attributes of medical complexity or predictor variables (eg, CCC categories) occurred.[19]

Covariates

Patient and hospital characteristics were defined by using standard categories provided by HCUP KID. Patient characteristics included age, gender, race/ethnicity, and payer. Age was analyzed in categories on the basis of American Academy of Pediatrics age groups 0 to 2, 3 to 5, 6 to 12, and 13 to 18. Race and ethnicity in HCUP KID are determined during each hospital's admission process. Race/ethnicity was categorized into 4 mutually exclusive groups: non-Latino white, non-Latino black, Latino, and other (includes Asian/Pacific Islander, Native American, and other). Primary payer was grouped into private, public (Medicaid and Medicare), self-pay, and other (other insurance [eg, military coverage] and no charge).

Hospital characteristics that are provided by HCUP KID include location (rural versus urban), region (Northeast, Midwest, South, or West), teaching status, and children's hospital designation. Hospital teaching status was determined from the National Association of Children's Hospitals and Related Institutions (NACHRI) through 2003 and the American Hospital Association Annual Survey Database in 2006. Children's hospital designation was determined from NACHRI classification criteria: nonchildren's hospital and children's hospital (children's general hospital, children's specialty hospital, children's unit in general hospital).

Statistical Analyses

We performed analyses taking into account the complex sampling and weighting scheme of HCUP KID using PROC SURVEY functions in SAS 9.1.3 (SAS Institute, Cary, NC).

We report inpatient health care use in each of the study years, including percentage and numbers of hospital admissions, days, and charges by CCC category count and percentage of hospital admissions, days, and charges by individual CCC. Associated 95% confidence intervals (CIs) for any CCC were also generated. Level of statistical significance is noted in addition to CIs. In addition, tests of linear trend of proportions in a logistic regression model were performed on percentage of hospital use (admissions, days, charges, and deaths), by both

CCC count and individual CCC, during the study period. Because of differences in sampling of hospitals in 1997, we additionally examined the trend of proportions of hospital use for any CCC from 2000 to 2006.

To facilitate direct comparisons between years for total charges, we converted 1997, 2000, and 2003 charges to 2006 dollars by using a consumer price index calculator (www.bls.gov/data/inflation_calculator.htm). Independent-sample *t* tests were also performed to compare 1997 use with subsequent years.

The proportion of admissions by patient and hospital characteristics were generated for each CCC category, with associated 95% CIs. Statistical significance was noted when CIs did not overlap.

To describe hospital use, we generated median LOS and median hospital charges with interquartile ranges. Annual rates of technology-assistance procedures and deaths were determined by calculating the number of weighted admissions for each category divided by the total numbers of weighted admissions, multiplied by 100.

We report for each year percentages of hospitalizations that were associated with technology-assistance procedures and deaths by CCC count. We performed univariate and multivariable analysis to evaluate the association of CCC category count with resource use. We performed general linear regression for models of log-transformed LOS and charges and logistic regression for models of technology-assistance procedures and death. For unadjusted models, we included only the CCC count variable. For adjusted models, we included all covariates (age, gender, payer, hospital location, hospital region, teaching status, and NACHRI designation) except race because >25% of observations were missing race data. The R^2 statistic provides a measure of how well the model accounts for variation in outcomes. The c statistic provides a measure of discriminative abilities; a model is "good" when the c statistic is >0.7 and "excellent" when >0.8.

RESULTS

Go to:

In 1997, 2000, 2003, and 2006, the HCUP KID provided, respectively, weighted estimates of 6.7, 6.6, 6.7, and 6.9 million discharges for children who were aged 0 to 18 years. Among children with multiple CCCs, the most frequent CCCs were cardiovascular (51.5%), congenital (46.9%), neuromuscular (37.1%), respiratory (22.2%), and malignancy (15.9%); the remaining CCCs were seen in <15% of children with multiple CCCs.

Across the 4 study years, inpatient admissions for children with CCCs accounted for an increasingly disproportionate number of pediatric hospital days and charges (Fig 1). CCCs accounted for 8.9% of US pediatric admissions in 1997 and 10.1% of admissions in 2006 (trend test $P < .0001$). These admissions accounted for 22.7% to 26.1% of pediatric hospital days ($P < .0001$) and 37.1% to 40.6% of pediatric hospital charges ($P < .0001$). Whereas proportions of hospital days were comparable between 1997 and 2000 ($P = .08$), proportions increased significantly from 2000 to 2003 ($P < .0001$) and 2003 to 2006 ($P < .0001$). Whereas proportions of hospital charges decreased from 1997 to 2000 ($P < .0001$), proportions increased significantly from 2000 to 2003 ($P < .0001$) and 2003 to 2006 ($P < .0001$).

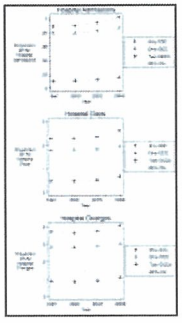

FIGURE 1

Inpatient health care use for US children from 1997 to 2006, by CCC. For any CCC, an increasing trend in proportion was seen across all study years ($P<.0001$), as well as the last 3 study years ($P<.0001$). Error bars (too small to be visible) ...

Whereas the total number of inpatient admissions and days for either 1 CCC or multiple CCCs was similar between 1997 and 2003, both increased in 2006 (Table 1). The total number of inpatient charges for either 1 CCC or multiple CCCs increased from 1997 to 2003 and from 1997 to 2006.

TABLE 1

Inpatient Health Care Use for US Children From 1997 to 2006, by CCC Count

Similar patterns are evident for most of the 9 CCC subtypes (Fig 2). The proportion of inpatient pediatric admissions, days, and charges increased from 1997 to 2006 for every CCC except hematology (admissions, days, charges) and respiratory (charges alone). The increase in proportion of admissions, days, and charges was most for those with cardiovascular, followed by neuromuscular, congenital, and metabolic CCCs.

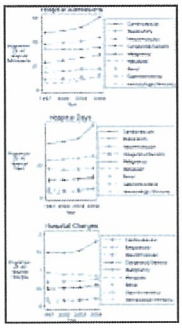

FIGURE 2

Inpatient health care use for US children from 1997 to 2006, by CCC. For each CCC except hematology (admissions, days, and charges) and respiratory (charges only), an increasing trend in proportion was seen across study years ($P<.0001$).

The patient and hospital characteristics of CCC-associated admissions are most clearly and pertinently understood by focusing on the 2006 study year (Table 2). Admissions for children with 1 and multiple CCCs compared with no CCCs was associated with patients who were older, were male, and had less self-pay and more other insurance. As numbers of CCCs increased, the proportion of admissions to urban, teaching, and children's hospitals increased.

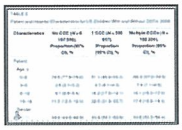

TABLE 2

Patient and Hospital Characteristics for US Children With and Without CCCs, 2006

As numbers of CCCs increased, all markers of use increased (Table 3). Compared with children with no CCCs, children with multiple CCCs had a threefold longer LOS, 11-fold greater charges, 60-fold higher rate of gastrostomy placement, 80-fold higher rate of tracheostomy placement, 180-fold higher rate of cerebrospinal fluid (CSF) shunt placement, and 15-fold higher inpatient mortality.

TABLE 3

Inpatient Use for US Children With and Without CCCs, 2006

CCCs identified a high proportion of patients who underwent placement of technology-assistance devices. In 1997, CCCs identified 67.2% of 12 043 gastrostomies, 59.3% of 912 tracheostomies, and 87.5% of 7255 CSF shunts. By 2006, CCCs identified 72.7% of 14 379 gastrostomies, 75.3% of 784 tracheostomies, and 91.8% of 7100 CSF shunts. Furthermore, CCCs identified 41.9% of 27 983 admissions that ended in death in 1997 and 43.2% of 26 493 admissions that ended in death in 2006 ($P = .0008$).

The CCC coding scheme identifies a subset of all admissions that display certain key attributes of medical complexity. In 2006 data, CCCs demonstrated statistically significant yet limited ability to account for variation in the number of inpatient hospital days (unadjusted $R^2 = 0.08$; adjusted $R^2 = 0.11$) and a greater ability to account for variation in charges (unadjusted $R^2 = 0.11$; adjusted $R^2 = 0.38$; Table 4). Models of CCCs alone were excellent for their discriminative ability with CSF shunt and gastrostomy tube placement with respective c

statistics of 0.89 and 0.80 and modest for tracheostomy tube placement and death with respective c statistics of 0.65 and 0.64. Models of CCCs that included other covariates (age, gender, payer, hospital location, hospital region, teaching status, and NACHRI designation) displayed excellent discriminative ability for CSF shunt and gastrostomy tube placement, good for inpatient mortality, and modest for tracheostomy tube placement.

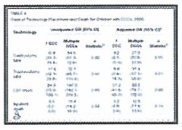

TABLE 4

Odds of Technology Placement and Death for Children with CCCs, 2006

DISCUSSION

Go to:

The use of pediatric inpatient hospital resources by patients who are admitted with CCCs both as an overall CCC group and as individual CCC types (excepting hematology) has increased over time. CCCs, long used to identify patients who are at risk for death,[11–15,20] are associated with substantial inpatient resource use, including LOS, charges, and particularly technology-assistance procedures. CCCs composed 10% of admissions, 25% of hospital days, 40% of hospital charges, 75% to 92% of technology-assistance procedures, and 43% of inpatient deaths among US children in 2006. Because individuals are not identified in this data set and patients with CCCs are more likely to be readmitted,[20] these 10% of admissions likely represent a smaller proportion of patients. This study also provides evidence that CCCs seem to identify, in hospital discharge data, a subset of all admissions that have attributes of medical complexity, specifically intensive resource use, particularly placement of technology-assistance devices (CSF shunts and gastrostomy tubes).

These findings should be interpreted with several caveats in mind. First, an adequate description of medically complex children has been elusive.[5–7] Various alternative strategies exist for their identification but tend to focus on smaller populations with particular diagnoses (eg, neurologic impairment[21]) or care needs (eg, palliative, end-of-life[22,23]). Second and related, we used a set of measures that we argue are attributes of medical complexity, rather than direct measurement of complexity per se; therefore, these should be considered candidate rather than definitive measures of medical complexity. In addition, these candidate measures should be considered for use at the population or health system level rather than the individual or clinical level. Third, use of administrative data has inherent limitations. For HCUP KID, the absence of patient identifiers limits the study to description and inferences about admissions, not patients. Some increase in CCCs during the study period may result from increased focus on documenting conditions for reimbursement purposes.

Fourth, ICD-9-CM codes do not characterize patients' functional limitations (or family needs, social factors, or the use of outpatient services or home-based technology that contribute to medical complexity), and some medically complex children may have other diagnoses that are not captured by CCCs. The net result is that CCCs do not identify the complete subset of all admissions of medically complex children. At the same time, as a recent systematic review argued,[7] the ready availability, consistency, and ease of use have made administrative data critical to the development of chronic condition definitions.[7] Within this framework of defining and measuring childhood chronic conditions, children with CCCs constitute (albeit not exclusively) the most intensive third subset of children with chronic conditions with increased health care use. Although the CCC classification scheme can and should be refined, such schemes can serve as useful pragmatic tools to identify a population of medically complex children.

This study provides evidence supporting the perception of an increase in both number and proportion of complex pediatric hospitalizations nationally.[5] This study confirms previous findings that children with chronic illness account for more use, including increasing inpatient hospital days,[4,8] higher expenditures,[8] more technology-dependent device use, and inpatient deaths.[4] Reasons for increasing inpatient use for medically complex children are unclear and likely multifactorial. The prevalence of children with CCCs in the US population may simply be increasing,[12] possibly as a result of improved survival in the neonatal period and subsequently prolonged survival.[24] This potential mechanism may explain the especially noticeable rise in the proportion of admissions

that are associated with cardiac, neuromuscular, metabolic, and congenital or genetic CCCs. Inpatient care for children with more common conditions (eg, asthma, gastroenteritis, urinary tract infection) may also be moving from inpatient to outpatient settings, leaving proportionately more children with CCCs in inpatient settings. Alternatively, the population of children with CCCs may be similar in size but their inpatient use may be increasing, particularly as they age. Reasons for the dramatic increase in cardiovascular CCC admissions, hospital days, and charges warrant additional study; adoption of complex cardiac interventions by lower volume centers, a national shift in increasing use of complex cardiac surgery,[25] or decreasing mortality among pediatric cardiac surgery patients[24] might, in part, contribute to this phenomenon.

These results can better inform a system of care for medically complex children. At the population or health system level, the use of CCCs or other classification schemes that can be implemented in large data sets would facilitate studies that evaluate both quality of and evidence in care provided to medically complex children. For example, the Institute of Medicine has prioritized evaluation of the medical home model for this population of children.[26–29] At the individual patient level, inpatient systems of care for medically complex children also need to be optimized. These fragile children are more vulnerable to safety issues in the inpatient setting.[30] Although CCC codes perform well at identifying a medically complex subset of all patients, they do not have adequate positive or negative predictive value for use at the individual or clinical level. We need to develop more robust prospective methods of identifying these children, potentially coupling diagnoses with more noncategorical characteristics, such as technology assistance and/or number of providers. Prospective identification coupled with effectiveness studies may improve our ability to care for these children in hospitals, with tools such as targeted medication reconciliation,[31] family-centered care,[32] teams of integrated providers in outpatient[27–29,33] and inpatient settings,[32] care pathways,[34] or portable medical records.[35] Finally, evidence to guide the provision of optimal inpatient health care for medically complex children remains very limited. High-quality research into the indications, complications, and outcomes of the more common technology-assistance procedures (eg, gastrostomy tubes, tracheostomies, CSF shunts[18,36–38]), coupled with dissemination of these findings, could substantially improve care for these children.

CONCLUSIONS

Go to:

CCCs, derived to identify patients who are at risk for death, are associated with intensive inpatient resource use, including LOS, charges, and technology-assistance procedures. CCCs identify a subset of all pediatric hospital admissions with increasing inpatient use nationally. Future research should seek to improve methods to identify medically complex children, monitor the trends of increasing use, and assess whether current systems of care are meeting the needs of medically complex children.

WHAT'S KNOWN ON THIS SUBJECT

Medically complex children are perceived to use a disproportionate amount of resources, particularly in the inpatient and tertiary care settings.

WHAT THIS STUDY ADDS

CCCs, derived to identify patients who are at risk for death, are associated with intensive inpatient resource use, including length of stay, charges, and technology-assistance procedures. CCCs identify a subset of all pediatric hospital admissions with increasing inpatient use nationally.

ACKNOWLEDGMENTS

Go to:

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and Dr Srivastava is the recipient of Eunice Kennedy Shriver National Institute for Child Health and Human Development award K23HD052553, and his work is also supported in part by the CHRC, University of Utah. None of the sponsors participated in design and conduct of the study; collection, management, analysis, and interpretation of the data; or preparation, review, or approval of the manuscript.

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ABBREVIATIONS

Go to:

CSHCN	children with special health care needs
CCC	complex chronic condition
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
HCUP KID	Healthcare Cost and Utilization Project Kids Inpatient Databases
LOS	length of stay
NACHRI	National Association of Children's Hospitals and Related Institutions
CI	confidence interval
CSF	cerebrospinal fluid

Footnotes

Go to:

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

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Abstract

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JAMA Pediatr. 2013 Feb;167(2):170-7. doi: 10.1001/jamapediatrics.2013.452.

Inpatient growth and resource use in 28 children's hospitals: a longitudinal, multi-institutional study.

Berry JG[1], Hall M, Hall DE, Kuo DZ, Cohen E, Agrawal R, Mandl KD, Clifton H, Neff J.

Author information

Abstract

OBJECTIVE: To compare inpatient resource use trends for healthy children and children with chronic health conditions of varying degrees of medical complexity.

DESIGN: Retrospective cohort analysis.

SETTING: Twenty-eight US children's hospitals.

PATIENTS: A total of 1 526 051 unique patients hospitalized from January 1, 2004, through December 31, 2009, who were assigned to 1 of 5 chronic condition groups using 3M's Clinical Risk Group software.

INTERVENTION: None.

MAIN OUTCOME MEASURES: Trends in the number of patients, hospitalizations, hospital days, and charges analyzed with linear regression.

RESULTS: Between 2004 and 2009, hospitals experienced a greater increase in the number of children hospitalized with vs without a chronic condition (19.2% vs 13.7% cumulative increase, $P < .001$). The greatest cumulative increase (32.5%) was attributable to children with a significant chronic condition affecting 2 or more body systems, who accounted for 19.2% (n = 63 203) of patients, 27.2% (n = 111 685) of hospital discharges, 48.9% (n = 1.1 million) of hospital days, and 53.2% ($9.2 billion) of hospital charges in 2009. These children had a higher percentage of Medicaid use (56.5% vs 49.7%; $P < .001$) compared with children without a chronic condition. Cerebral palsy (9179 [14.6%]) and asthma (13 708 [21.8%]) were the most common primary diagnosis and comorbidity, respectively, observed among these patients.

CONCLUSIONS: Patients with a chronic condition increasingly used more resources in a group of children's hospitals than patients without a chronic condition. The greatest growth was observed in hospitalized children with chronic conditions affecting 2 or more body systems. Children's hospitals must ensure that their inpatient care systems and payment structures are equipped to meet the protean needs of this important population of children.

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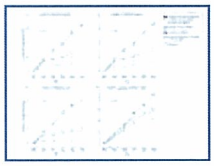
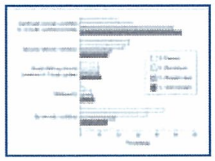

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H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

AHRQ Agency for Healthcare Research and Quality

STATISTICAL BRIEF #169

January 2014

Trends in Pediatric and Adult Hospital Stays for Asthma, 2000–2010

Marguerite L. Barrett, M.S., Lauren M. Wier, M.P.H., and Raynard Washington, Ph.D., M.P.H.

Introduction

Asthma is a chronic disease characterized by inflammation of the airways. It restricts the passage of air into the lungs and leads to episodes of wheezing, coughing, chest tightness, and shortness of breath. Severe asthmatic episodes can close off airways completely and, in some cases, may be life-threatening.[1]

In 2010, approximately 7.0 million children aged 0–17 years and 18.7 million adults aged 18 years and older had a diagnosis of asthma. The prevalence of asthma in the United States has increased from 7.3 percent of the population in 2001 to 8.4 percent in 2010.[2]

Asthma is largely controllable with proper primary care, and the need for hospitalization can usually be prevented. However, differences in rates of hospitalization for asthma suggest that there is significant room for improvement in caring for the condition.

This Statistical Brief presents data from the Healthcare Cost and Utilization Project (HCUP) on trends in pediatric and adult inpatient hospital stays for asthma at U.S. community hospitals from 2000 through 2010. In addition, we present patient characteristics of pediatric and adult hospital stays for asthma in 2010. Differences that are noted in the text exhibit at least a 10 percent difference between estimates and are statistically significant at 0.05 or better.

Highlights

- From 2000 through 2010, the rate of pediatric hospital stays for asthma declined from 165 to 130 per 100,000 population, respectively, whereas the rate for adults remained about 119 per 100,000 population.
- The average cost per asthma-related hospital stay for children remained relatively stable at about $3,600 from 2000 to 2010, whereas the average cost per asthma-related hospital stay for adults increased from $5,200 to $6,600.
- Among children, the rate of hospital stays for asthma was 54 percent higher for males than females. This pattern was reversed among adults: females had a 129 percent higher rate of hospital stays than males.
- Rates of asthma-related admission were more than three times higher among African American children and two times higher for African American adults compared with White and Asian and Pacific Islander patients.
- Pediatric and adult patients in the lowest income communities had consistently higher rates of hospital stays for asthma than those in the highest income communities.
- Medicaid was the most frequent expected primary payer among children and adults aged 18–44 years; private insurance was the second most frequent payer.

[1] U.S. Department of Health and Human Services (HHS). Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Publication No. 07–4051. Bethesda, MD: HHS, National Heart, Lung and Blood Institute, National Institutes of Health; 2007.

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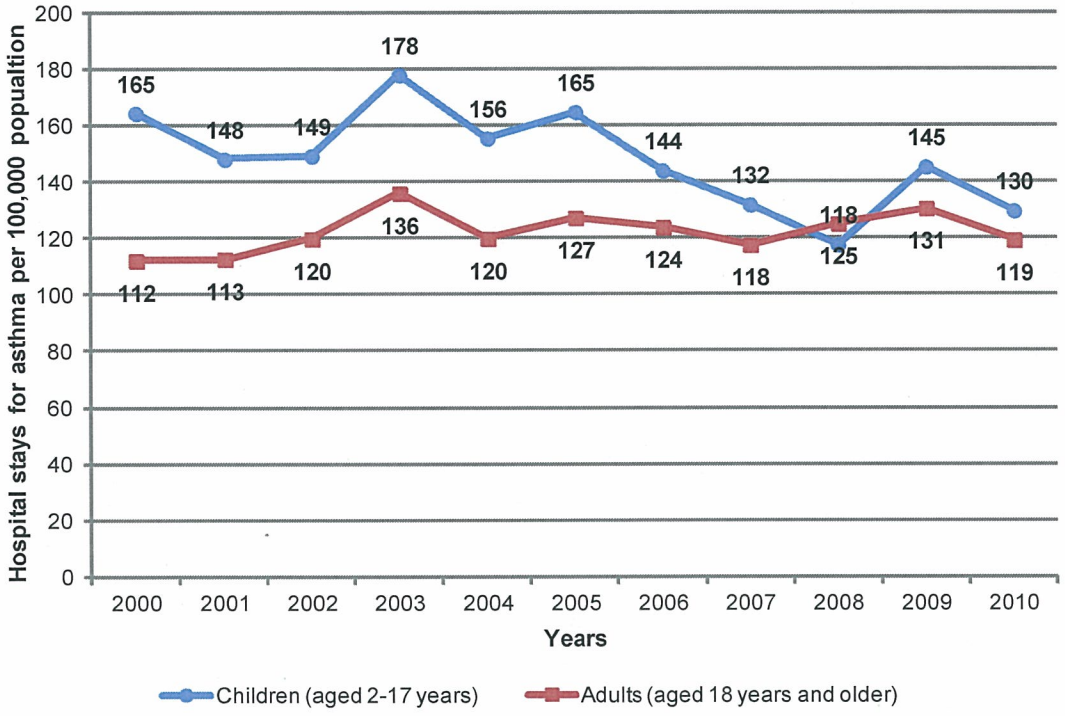
Findings

Rate of pediatric and adult hospital stays for asthma, 2000–2010

Figure 1 displays the age- and sex-adjusted rates of hospital stays for asthma from 2000 through 2010 for children (aged 2–17 years) and adults (aged 18 years and older).[3] The rate of pediatric asthma-related hospital stays declined from about 165 per 100,000 population in 2000 to 130 per 100,000 population in 2010. Although there was some variation across years, the rate of adult asthma-related hospital stays remained relatively unchanged between 2000 and 2010 at about 119 hospital stays per 100,000 population. The rate of pediatric hospital stays was higher than the rate of adult hospital stays for asthma from 2000 through 2005; pediatric and adult rates were similar from 2006 through 2010.

Figure 1. Trends in the rate of hospital stays for asthma per 100,000 population for children and adults, 2000–2010



Note: Rates are adjusted for age and sex.

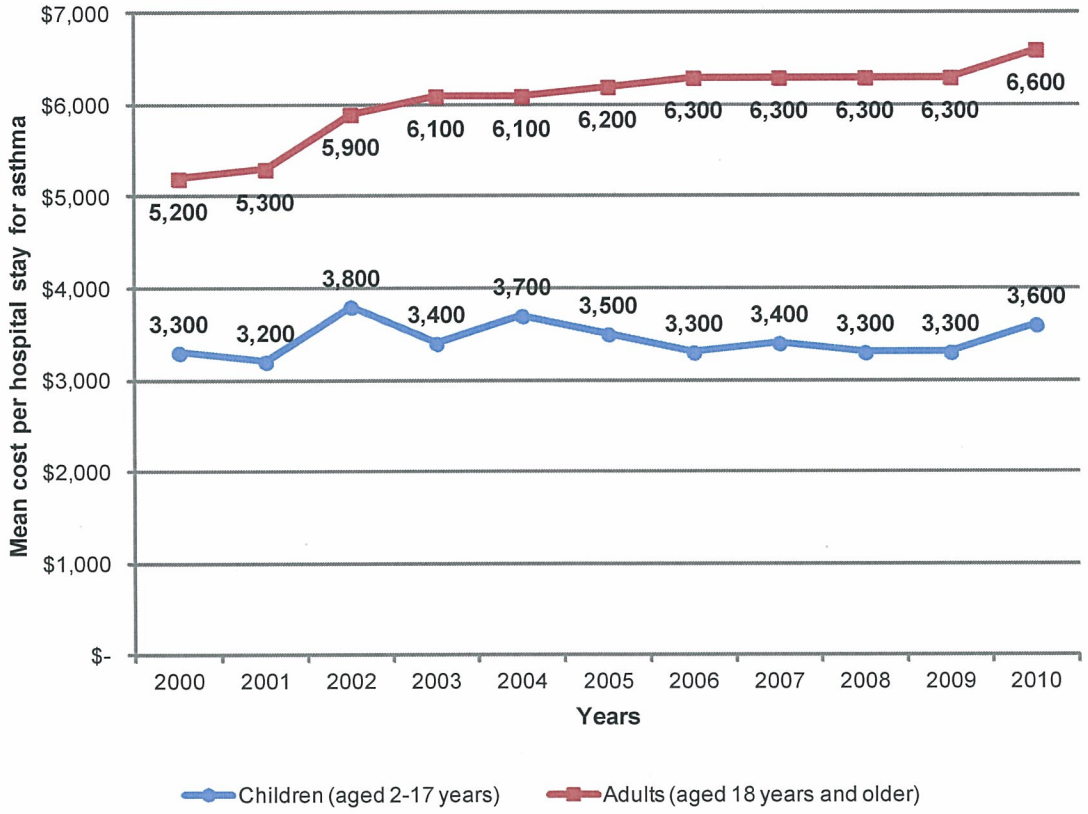
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 2000–2010, and AHRQ Prevention Quality Indicators (PQIs)

[3] Consistent with the AHRQ Quality Indicator for pediatric asthma, hospital stays for patients younger than 2 years were excluded because an asthma diagnosis in younger children may be difficult to distinguish from bronchospasm.

Average cost of pediatric and adult hospital stays for asthma, 2000–2010

Figure 2 displays the average inflation-adjusted cost of hospital stays for asthma from 2000 through 2010 for children (aged 2–17 years) and adults (aged 18 years and older). The average cost per hospital stay for children with asthma remained relatively stable at about $3,600 from 2000 to 2010. During this same period, the average cost per adult asthma-related hospital stay increased from $5,200 to $6,600. The average cost per hospital stay for asthma was consistently higher for adults than children across all years.

Figure 2. Trends in the average cost of hospital stays for asthma for children and adults, 2000–2010



Note: Costs were adjusted for inflation to 2010 using the price index for the gross domestic product.

Source: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 2000–2010, and AHRQ Prevention Quality Indicators (PQIs)

Rate of pediatric and adult hospital stays for asthma by patient characteristics, 2010
Table 1 displays the rate of asthma-related hospital stays for children and adults by patient characteristics. In 2010, the rate of hospital stays for asthma was similar for children (129.7 per 100,000 population) and adults (119.3 per 100,000 population). Among children, the rate of hospital stays for asthma was 54 percent higher for males than females (156.5 versus 101.7 stays per 100,000 population). This pattern was reversed among adults: females had a 129 percent higher rate of hospital stays than males (163.0 versus 71.2 hospital stays per 100,000 population). Across both age groups, African American and Hispanic patients had higher rates of asthma relative to White and Asian and Pacific Islander patients in 2010. Notably, hospitalization rates were more than three times higher for African American children and two times higher for African American adults compared with White and with Asian and Pacific Islander patients. Pediatric and adult patients in the lowest income communities had higher rates of hospital stays for asthma than those in the highest income communities.

Table 1. Adjusted rate of hospital stays for asthma per 100,000 population for children and adults, 2010

Patient characteristic	Hospital stays for asthma per 100,000 population	
	Children (aged 2–17 years)	Adults (aged 18 years and older)
Total U.S.	129.7	119.3
Sex		
Male	156.5	71.2
Female	101.7	163.0
Race/ethnicity		
Non-Hispanic		
White	83.8	90.5
African American	363.9	297.9
Asian and Pacific Islander	78.2	65.4
Hispanic (of any race)	128.8	144.6
Community-level income		
First quartile (lowest income)	182.8	194.3
Second quartile	123.7	117.4
Third quartile	113.9	100.0
Fourth quartile (highest income)	95.2	72.6
Location of patient residence		
Large metropolitan	140.6	139.1
Small metropolitan	124.9	94.5
Micropolitan	97.6	99.2
Not metropolitan or micropolitan	104.0	110.0
Location of inpatient treatment		
Northeast	176.8	167.6
Midwest	104.6	120.5
South	130.3	120.8
West	119.7	76.5

Note: Rates are adjusted for age and sex.

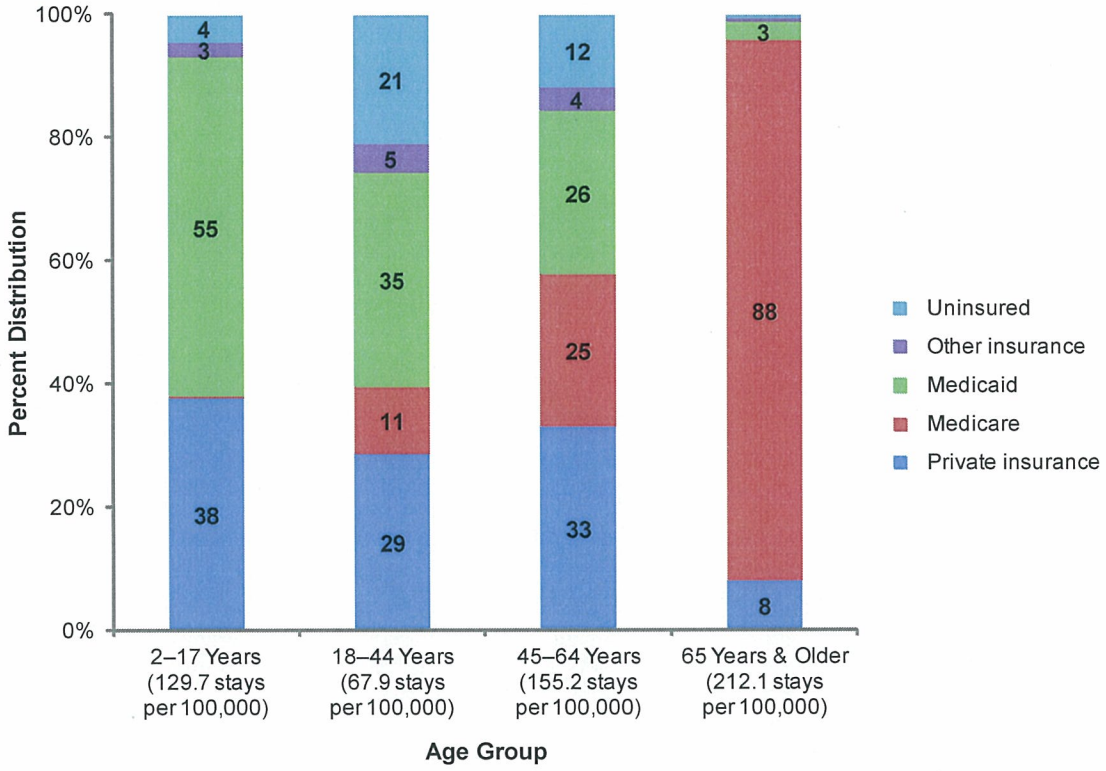
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS) and State Inpatient Databases (SID) disparities analytic file, 2010, and AHRQ Prevention Quality Indicators (PQIs)

Adults residing in large metropolitan areas had a higher rate of hospital stays for asthma (139.1 per 100,000 population) than adults residing in other areas. Children residing in large metropolitan areas had a higher rate of hospital stays for asthma (140.6 per 100,000 population) than children residing in micropolitan areas only (97.6 per 100,000 population). Adults treated in the Northeast had a higher rate of hospital stays for asthma (167.6 per 100,000 population) than adults in other Census regions. Children treated in the Northeast had a significantly higher rate of hospital stays for asthma (176.8 per 100,000 population) than children treated in the Midwest only (104.6 per 100,000 population).

Distribution of stays by age group and expected primary payer, 2010

Figure 3 shows that Medicaid was the largest expected primary payer of hospital stays for asthma among children aged 2–17 years (55 percent) and adults aged 18–44 years (35 percent). Private insurance was the second largest primary payer of hospital stays for asthma among these same two age groups (children, 38 percent; adults aged 18–44 years, 29 percent). Among adults aged 45–64 years, private insurance was the payer for one-third of all asthma-related hospital stays, and Medicaid and Medicare each were payers for about one-fourth of these stays. Among patients aged 65 years and older, nearly 9 out of 10 hospital stays for asthma were billed to Medicare. The proportion of asthma-related hospital stays that were uninsured was highest among patients aged 18–44 years (21 percent), followed by patients aged 45–64 years (12 percent).

Figure 3. Distribution of hospital stays for asthma by age group and primary expected payer, 2010



Note: Percentages less than 2 percent are not labeled. The Medicare percentage for children aged 2–17 years is not visible because it is only 0.2 percent.

Source: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS), 2010, and AHRQ Prevention Quality Indicators (PQIs)

Data Source

The estimates in this Statistical Brief are based upon data from the Healthcare Cost and Utilization Project (HCUP) 2000–2010 Nationwide Inpatient Sample (NIS) and a 2010 disparities analysis file (see description below) created from the State Inpatient Databases (SID). The disparities analysis file is designed to provide national estimates on racial disparities using weighted records from a sample of hospitals in the SID.

Differences that are noted in the text exhibit at least a 10 percent difference between estimates and achieved a level of statistical significance of 0.05 or better.

State Inpatient Databases disparities analysis file
Measures of race and ethnicity can be problematic in hospital discharge databases. Some States do not collect information on race and ethnicity from hospitals and, within States that collect the information, some hospitals do not code race and ethnicity reliably. A disparities analysis file designed to provide national estimates by race and ethnicity was constructed using the HCUP SID from participating States that report patient race and ethnicity. This file was created using a stratified, weighted sample of hospitals with good reporting of these measures. It contains data from about 2,000 hospitals and is a 40-percent sample of community, nonrehabilitation hospitals in the United States.

For 2010, SID data from the following 37 States were used: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Montana, Mississippi, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Wisconsin, and Wyoming.

Definitions

Diagnoses and ICD-9-CM
The *principal diagnosis* is that condition established after study to be chiefly responsible for the patient's admission to the hospital. *Secondary diagnoses* are concomitant conditions that coexist at the time of admission or develop during the stay.

ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses. There are approximately 14,000 ICD-9-CM diagnosis codes.

Case definition: asthma
Rates of asthma hospital stays for adults and children were based on the AHRQ Prevention Quality Indicators (PQIs) for asthma (PQI #15 for adults and PDI #14 for children), version 4.1. Rates were adjusted by age and sex using the 2000 United States population as the standard[4].

The numerator (outcome of interest) of the rate included the following:

- Inpatient hospital stays with an ICD-9-CM principal diagnosis code of asthma, defined as one of the following codes:
  - 49300 EXT ASTHMA W/O STAT ASTH
  - 49301 EXT ASTHMA W STATUS ASTH
  - 49302 EXT ASTHMA W ACUTE EXAC OCT00
  - 49310 INT ASTHMA W/O STAT ASTH
  - 49311 INT ASTHMA W STATUS ASTH
  - 49312 INT ASTHMA W ACUTE EXAC OCT00
  - 49320 CH OB ASTH W/O STAT ASTH
  - 49321 CH OB ASTHMA W STAT ASTH
  - 49322 CH OBS ASTH W ACUTE EXAC OCT00

[4] U.S. Census Bureau, Population Division. Intercensal Estimates of the Resident Population by Single Year of Age, Sex, Race,and Hispanic Origin for the United States: April 1, 2000 to July 1, 2010. September 2011. http://www.census.gov/popest/data/intercensal/national/nat2010.html.

- 49381 EXERCSE IND BRONCHOSPASM OCT03
- 49382 COUGH VARIANT ASTHMA OCT03
- 49390 ASTHMA W/O STATUS ASTHM
- 49391 ASTHMA W/ STATUS ASTHM
- 49392 ASTHMA W ACUTE EXACERBTN OCT00

- Adults must be 18 years or older or any age if identified on a maternal record. Maternal is defined by the major diagnostic category (MDC) of 14 for pregnancy, childbirth, and puerperium. Children are limited to nonmaternal hospital stays aged 2 through 17 years old. Consistent with the AHRQ Quality Indicator for pediatric asthma, hospital stays for patients younger than 2 years were excluded because an asthma diagnosis in younger children may be difficult to distinguish from bronchospasm.

- Hospital stays were excluded for any one of the following reasons:
  - Hospital stay was transferred into the hospital from another acute care hospital, skilled nursing facility, intermediate care facility, or other health care facility
  - Hospital stay had any ICD-9-CM diagnosis code of cystic fibrosis or anomalies of the respiratory system, defined as one of the following:
    - 27700 CYSTIC FIBROS W/O ILEUS
    - 27701 CYSTIC FIBROS W ILEUS
    - 27702 CYSTIC FIBROS W PUL MAN
    - 27703 CYSTIC FIBROSIS W GI MAN
    - 27709 CYSTIC FIBROSIS NEC
    - 74721 ANOMALIES OF AORTIC ARCH
    - 7483 LARYNGOTRACH ANOMALY NEC
    - 7484 CONGENITAL CYSTIC LUNG
    - 7485 AGENESIS OF LUNG
    - 74860 LUNG ANOMALY NOS
    - 74861 CONGEN BRONCHIECTASIS
    - 74869 LUNG ANOMALY NEC
    - 7488 RESPIRATORY ANOMALY NEC
    - 7489 RESPIRATORY ANOMALY NOS
    - 7503 CONG ESOPH FISTULA/ATRES
    - 7593 SITUS INVERSUS
    - 7707 PERINATAL CHR RESP DIS

The denominator (population at risk) of the rate is the national population specific to the age group: 2 through 17 years for children and 18 years and older for adults.

Prevention Quality Indicators

The Prevention Quality Indicators (PQIs; version 4.1), a component of the AHRQ Quality Indicators (QIs), are a set of measures that can be used with hospital inpatient hospital stay data to identify access to and quality of care for ambulatory care-sensitive conditions. These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. PQI rates can also be affected by other factors such as disease prevalence. The PQIs are adjusted for age and sex.

Further information on the AHRQ QIs, including documentation and free software downloads, is available at http://www.qualityindicators.ahrq.gov/. It also includes information on the Pediatric Quality Indicators (PDIs, formerly referred to as PedQIs). The PDIs contain measures of potentially preventable hospitalizations for children for asthma, gastroenteritis, diabetes short-term complications, and perforated appendix. Additional information on how the QI software was applied to the HCUP data for the statistics reported in this Statistical Brief is available in Coffey et al., 2012.[5]

[5] Coffey R, Barrett M, Houchens R, Moy E, Andrews R, Coenen N. Methods Applying AHRQ Quality Indicators to Healthcare Cost and Utilization Project (HCUP) Data for the Eleventh (2013) National Healthcare Quality Report (NHQR) and National Healthcare Disparities Report (NHDR). HCUP Methods Series Report #2012-03. Online. November 12, 2012. U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/methods/2012_03.pdf. Accessed December 4, 2013.

Types of hospitals included in HCUP
HCUP is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). HCUP data include obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care, rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. However, if a patient received long-term care, rehabilitation, or treatment for psychiatric or chemical dependency conditions in a community hospital, the hospital stay record for that stay will be included in the Nationwide Inpatient Sample (NIS) and the SID disparities analysis file.

Unit of analysis
The unit of analysis is the hospital hospital stay (i.e., the hospital stay), not a person or patient. This means that a person who is admitted to the hospital multiple times in one year will be counted each time as a separate "hospital stay" from the hospital.

Costs and charges
Total hospital charges were converted to costs using HCUP Cost-to-Charge Ratios based on hospital accounting reports from the Centers for Medicare & Medicaid Services (CMS).[6] *Costs* will reflect the actual expenses incurred in the production of hospital services, such as wages, supplies, and utility costs; charges represent the amount a hospital billed for the case. For each hospital, a hospital-wide cost-to-charge ratio is used. Hospital charges reflect the amount the hospital billed for the entire hospital stay and do not include professional (physician) fees. For the purposes of this Statistical Brief, costs are reported to the nearest hundred. Costs were deflated to 2010 using the price index for the gross domestic product.[7]

Patients' race and ethnicity
HCUP uniform coding includes race and ethnicity in one data element (RACE). Because of variability in the collection of race and ethnicity information in the State data provided to HCUP, HCUP maintains a uniform set of categories based on race definitions used in the 1977 Office of Management and Budget (OMB) Directive 15. It uses the combined race-ethnicity format (separate categories for Hispanic and five non-Hispanic racial groups—White, Black, Asian and Pacific Islander, American Indian or Alaska Native, and Other). When a State and its hospitals collect Hispanic ethnicity *separately* from race, HCUP assigns the data to the combined race and ethnicity categorization and uses Hispanic ethnicity to override any other race category to create uniform coding across States. There is limited reporting of American Indian or Alaska Native (AIAN) in the HCUP data, so statistics for this group were not presented.

This Statistical Brief reports race and ethnicity for the following categories: White non-Hispanic, African American non-Hispanic, Asian or Pacific Islander non-Hispanic, and Hispanic (of any race).

Median community-level income
Median community-level income is the median household income of the patient's ZIP Code of residence. The cut-offs for the quartile designation are determined yearly using ZIP Code demographic data obtained from the Nielsen Company. The income quartile is set to the lowest income for homeless patients.

Location of patients' residence
Place of residence is based on a simplified adaptation of the 2003 version of the Urban Influence Codes (UIC). The 12 categories of the UIC are combined into four broader categories that differentiate between large metropolitan areas with a population of 1 million or more residents, small metropolitan areas with a population less than 1 million residents, micropolitan areas, and nonurban residual areas that are neither metropolitan or micropolitan.

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[6] HCUP Cost-to-Charge Ratio Files (CCR). Healthcare Cost and Utilization Project (HCUP). 2001-2009. U.S. Agency for Healthcare Research and Quality, Rockville, MD. Updated August 2013. http://www.hcup-us.ahrq.gov/db/state/costtocharge.jsp. Accessed December 17, 2013.

[7] U.S. Department of Commerce Bureau of Economic Analysis. National Income and Product Accounts Tables. Section 1, Domestic Product and Income. http://www.bea.gov/iTable/iTable.cfm?ReqID=9&step=1#. Accessed December 4, 2013.

Location of inpatient treatment
Location is based on the region of the treatment hospital and is one of the four regions defined by the U.S. Census Bureau:

- Northeast: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania
- Midwest: Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas
- South: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas
- West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska, and Hawaii

Payer
Payer is the expected primary payer for the hospital stay. To make coding uniform across all HCUP data sources, payer combines detailed categories into general groups:

- Medicare: includes patients covered by fee-for-service and managed care Medicare
- Medicaid: includes patients covered by fee-for-service and managed care Medicaid
- Private Insurance: includes Blue Cross, commercial carriers, and private health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
- Other: includes Medicare, Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs. Uninsured: includes an insurance status of "self-pay" and "no charge."

Hospital stays billed to the State Children's Health Insurance Program (SCHIP) may be classified as Medicaid, Private Insurance, or Other, depending on the structure of the State program. Because most State data do not identify SCHIP patients specifically, it is not possible to present this information separately.

When more than one payer is listed for a hospital stay, the first-listed payer is used.

About HCUP

HCUP is a family of powerful health care databases, software tools, and products for advancing research. Sponsored by the Agency for Healthcare Research and Quality (AHRQ), HCUP includes the largest all-payer encounter-level collection of longitudinal health care data (inpatient, ambulatory surgery, and emergency department) in the United States, beginning in 1988. HCUP is a Federal-State-Industry Partnership that brings together the data collection efforts of many organizations—such as State data organizations, hospital associations, private data organizations, and the Federal government—to create a national information resource.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

Alaska State Hospital and Nursing Home Association
Arizona Department of Health Services
Arkansas Department of Health
California Office of Statewide Health Planning and Development
Colorado Hospital Association
Connecticut Hospital Association
Florida Agency for Health Care Administration
Georgia Hospital Association
Hawaii Health Information Corporation
Illinois Department of Public Health

Indiana Hospital Association
Iowa Hospital Association
Kansas Hospital Association
Kentucky Cabinet for Health and Family Services
Louisiana Department of Health and Hospitals
Maine Health Data Organization
Maryland Health Services Cost Review Commission
Massachusetts Center for Health Information and Analysis
Michigan Health & Hospital Association
Minnesota Hospital Association
Mississippi Department of Health
Missouri Hospital Industry Data Institute
Montana MHA - An Association of Montana Health Care Providers
Nebraska Hospital Association
Nevada Department of Health and Human Services
New Hampshire Department of Health & Human Services
New Jersey Department of Health
New Mexico Department of Health
New York State Department of Health
North Carolina Department of Health and Human Services
North Dakota (data provided by the Minnesota Hospital Association)
Ohio Hospital Association
Oklahoma State Department of Health
Oregon Association of Hospitals and Health Systems
Oregon Health Policy and Research
Pennsylvania Health Care Cost Containment Council
Rhode Island Department of Health
South Carolina Budget & Control Board
South Dakota Association of Healthcare Organizations
Tennessee Hospital Association
Texas Department of State Health Services
Utah Department of Health
Vermont Association of Hospitals and Health Systems
Virginia Health Information
Washington State Department of Health
West Virginia Health Care Authority
Wisconsin Department of Health Services
Wyoming Hospital Association

About the NIS

The HCUP Nationwide Inpatient Sample (NIS) is a nationwide database of hospital inpatient stays. The NIS is nationally representative of all community hospitals (i.e., short-term, non-Federal, nonrehabilitation hospitals). The NIS is a sample of hospitals and includes all patients from each hospital, regardless of payer. It is drawn from a sampling frame that contains hospitals comprising more than 95 percent of all discharges in the United States. The vast size of the NIS allows the study of topics at both the national and regional levels for specific subgroups of patients. In addition, NIS data are standardized across years to facilitate ease of use.

About the SID

The HCUP State Inpatient Databases (SID) are hospital inpatient databases from data organizations participating in HCUP. The SID contain the universe of the inpatient discharge abstracts in the participating HCUP States, translated into a uniform format to facilitate multistate comparisons and analyses. Together, the SID encompass more than 95 of all U.S. community hospital discharges in 2011. The SID can be used to investigate questions unique to one State, to compare data from two or more States, to conduct market area variation analyses, and to identify State-specific trends in inpatient care utilization, access, charges, and outcomes.

About HCUPnet

HCUPnet is an online query system that offers instant access to the largest set of all-payer health care databases publicly available. HCUPnet has an easy step-by-step query system, allowing for tables and graphs to be generated on national and regional statistics as well as trends for community hospitals in the United States. HCUPnet generates statistics using data from HCUP's Nationwide Inpatient Sample (NIS), the Kids' Inpatient Database (KID), the Nationwide Emergency Department Sample (NEDS), the State Inpatient Databases (SID), and the State Emergency Department Databases (SEDD).

For More Information

For more information about HCUP, visit http://www.hcup-us.ahrq.gov/.

For additional HCUP statistics, visit HCUPnet, our interactive query system, at http://hcupnet.ahrq.gov/.

For information on other hospitalizations in the United States, refer to the following HCUP Statistical Briefs located at http://www.hcup-us.ahrq.gov/reports/statbriefs/statbriefs.jsp:

- Statistical Brief #166, Overview of Hospital Stays in the United States, 2011
- Statistical Brief #168, Costs for Hospital Stays in the United States, 2011
- Statistical Brief #162, Most Frequent Conditions in U.S. Hospitals, 2011
- Statistical Brief #165, Most Frequent Procedures Performed in U.S. Hospitals, 2011

For a detailed description of HCUP, more information on the design of the Nationwide Inpatient Sample (NIS), and methods to calculate estimates, please refer to the following publications:

Introduction to the HCUP Nationwide Inpatient Sample, 2011. Online. June 2013. U.S. Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/db/nation/nis/NIS_Introduction_2011.pdf. Accessed December 4, 2013.

Introduction to the HCUP State Inpatient Databases, 2011. Online. August 2013. U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/db/state/siddist/Introduction_to_SID.pdf. Accessed December 4, 2013.

Houchens R, Elixhauser A. Final Report on Calculating Nationwide Inpatient Sample (NIS) Variances, 2001. HCUP Methods Series Report #2003-2. Online. June 2005 (revised June 6, 2005). U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/CalculatingNISVariances200106092005.pdf. Accessed December 4, 2013.

Houchens RL, Elixhauser A. Using the HCUP Nationwide Inpatient Sample to Estimate Trends. (Updated for 1988–2004). HCUP Methods Series Report #2006–05. Online. August 18, 2006. U.S. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/methods/2006_05_NISTrendsReport_1988-2004.pdf. Accessed December 4, 2013.

Suggested Citation

Barrett ML (ML Barrett, Inc), Wier LM (Truven Health Analytics), and Washington R (AHRQ). Trends in Pediatric and Adult Hospital Stays for Asthma, 2000–2010. HCUP Statistical Brief #169. January 2014. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb169-Asthma-Trends-Hospital-Stays.pdf.

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United

States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at hcup@ahrq.gov or send a letter to the address below:

Irene Fraser, Ph.D., Director
Center for Delivery, Organization, and Markets
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

Exhibit 4

EMERGENCY PATIENT TRANSFER AGREEMENT

THIS EMERGENCY PATIENT TRANSFER AGREEMENT (the "Agreement") is made and entered into this 1 day of June, 2015 (the "Effective Date") by and between **THE HOSPITAL OF CENTRAL CONNECTICUT**, a Connecticut corporation, having its principal offices at 100 Grand Street, New Britain, CT 06050 (hereinafter referred to as "HOCC") and **CONNECTICUT CHILDREN'S MEDICAL CENTER**, a Connecticut corporation, having its principal offices at 282 Washington Street, Hartford, Connecticut 06106 (hereinafter referred to as "Connecticut Children's").

RECITALS

WHEREAS, Connecticut Children's and HOCC desire to arrange for the transfer of patients in certain situations wherein either hospital may be unable to provide the needed emergency medical care required by one or more patients; and

WHEREAS, subject to capacity and the available expertise, Connecticut Children's and HOCC desire to accept such patients in order to provide them with the appropriate care.

NOW THEREFORE, in consideration of the promises and mutual covenants, agreements and undertakings set forth below, HOCC and Connecticut Children's hereby agree as follows:

1. Transfer of Patients.

(a) Transfer Request and Acceptance. Upon request by the transferring hospital's emergency department physician, patients will be transferred for evaluation and/or admission to Connecticut Children's or HOCC as the case may be, unless denied in accordance with this Agreement. The transferring physician shall be responsible for evaluating the patient's condition and needs to detetmine the appropriateness or advisability of transfer. In any case in which the transferring physician determines that a transfer is medically necessary and/or appropriate in accordance with state and federal law, the transferring physician shall contact Connecticut Children's or HOCC as the case may be to ascertain the respective hospital's capacity and capability to accept the patient and to initiate the transfer where appropriate. Connecticut Children's and HOCC may refuse to accept a requested transfer only if such hospital does not have the "capacity" (as such term is defined by the Emergency Medical Treatment and Labor Act and the regulations promulgated thereunder ("EMTALA")) to meet the patient's needs.

(b) Conditions of Transfer. Nothing in this Agreement shall be construed to state or supersede a patient's choice of service location; provided such choice is consistent with applicable state and federal laws. In the event of patient transfer, the transferring physician shall inform the patient (and the parent(s) or guardian(s) unless the patient is emancipated or otherwise legally authorized to consent to treatment) of the advisability,

advantages, disadvantages (if applicable) or necessity of transfer and, if possible, obtain the consent of either the patient's parent(s) or guardian(s) or the patient if the patient is legally authorized to consent to the transfer. Connecticut Children's and HOCC agree that each will accept patients for necessary emergency services without regard to their ability to pay.

2. Transportation. All arrangements for transfer of the patient shall be coordinated by the transferring hospital physician with the receiving hospital physician. The transferring physician shall provide such medical treatment as may be indicated by the patient's condition within the capabilities of available staff and facilities, in order to stabilize the patient and minimize the risks of transfer to the patient's health, and, in consultation with the receiving physician, shall determine the selection of transportation and the level of care required for management of the patient *en route*. The transferring hospital shall provide qualified health care practitioner(s) to accompany the patient if needed as it so determines. Once transfer of a patient is physically established, the transferring health care practitioner shall clarify medical control. Records shall be kept during transport in the transferring hospital's medical records. Communication shall be maintained with access to medical direction during transport. Neither party assumes responsibility for any charges related to transportation by an independent third party or any personal injury, loss, damage or death occurring during transportation of the patient by an independent third party.

3. Medical Records and Personal Effects. The transferring hospital shall provide a copy of all appropriate clinical information pertinent to determining appropriateness of care and maintaining an integrated continuum of care, including but not limited to the patient's medical record, which shall accompany the patient to the receiving hospital at the time of transfer. The transferring hospital will send with each patient at the time of transfer, or if delay would increase the risk of transfer, as promptly thereafter as possible, the completed transfer and referral forms mutually agreed upon by HOCC and Connecticut Children's to provide the medical and administrative information necessary to determine the appropriateness of the transfer and to enable continuing care to the patient. The transfer and referral form will include such information as: name, address and phone number of referring physician; informed consent for the transfer, if possible; certification that the transfer is medically indicated; nature of injury/event, medical findings; medical history, including pre-hospital care; diagnosis; a brief summary of the course of treatment; operative and anesthesia management information; response to treatment, nursing information including vital signs; laboratory and x-ray findings; blood or blood products received, ambulation status; pertinent administrative and social information including patient's name and age and name, address and phone number of next of kin; and name and telephone number of the physician who transferred the patient and the name and telephone number of the physician who accepted the transfer. If the patient is returned to the transferring hospital after treatment at the receiving hospital, copies of all medical records pertinent to the patient at the time of transfer shall be sent.

The transferring hospital will send with each patient at the time of transfer, or in

the case of emergency, as promptly as possible, a completed inventory form documenting the personal effects transferred with the patient. The transferring hospital will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items. The transferring hospital shall arrange for the transfer of personal effects and will be responsible for those personal effects until signed for by the receiving hospital.

4. Performance Improvement, Education and Research. Whenever possible, each party shall cooperate with the other party in the development and implementation of any patient transfer, process and performance improvement program(s). Whenever possible, each party shall make information concerning its services available to the other party's physicians to assist them in evaluating the appropriateness of transfers. The parties shall jointly participate in transfer review conferences and morbidity and mortality conferences relating to such transfers.

5. Confidentiality. Each party agrees to maintain the confidentiality of patients' health information in accordance with state and federal law and regulation, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations.

6. Insurance. Throughout the term of this Agreement, each party shall carry property and general liability insurance in the amount of$2,000,000 per occurrence and $4,000,000 in the aggregate at no cost to the other party. Each party shall be named as an additional insured under the other party's insurance. Each party shall provide the other party with a certificate of insurance evidencing the limits of such insurance and the other party's status as an additional insured, within ten (10) days of the other party's request from time to time to such party.

Promptly after receipt by a party of the commencement of any claim, demand, action, suit or proceeding (collectively, "Action") involving a patient transferred hereunder, such party shall notify the other party of the commencement of the Action.

7. Advertising and Public Relations. Neither party shall use the name of the other party in any promotional or advertising material without the prior written approval of the institution whose name is to be used.

8. Term and Termination. This Agreement shall commence on the Effective Date hereof and shall continue for a period of one (1) year. Thereafter, this Agreement shall be automatically renewed for one (1) year periods, unless terminated as provided herein. This Agreement may be terminated by either party upon thirty (30) days prior written notice to the other party. This Agreement shall terminate immediately if either party fails to maintain its license, certification or accreditation. Either party may immediately terminate this Agreement if the other party is in material default under the terms of this Agreement or is unable to provide the services contemplated by this Agreement.

9. **Miscellaneous.**

(a) Each of the parties expressly agrees that in the performance of this Agreement, it shall not discriminate or permit discrimination against any person or group of persons based upon race, color, religious creed, age, ancestry, national origin, gender, marital status, mental retardation, physical disability, blindness or other disability, in any manner prohibited by the laws of the United States or of the State of Connecticut.

(b) All notices of any nature referred to in this Agreement shall be in writing and sent by registered or certified mail, postage prepaid, to the respective addresses set forth below or to such other addresses as the respective parties hereto may designate in writing.

To Connecticut Children's:
Connecticut Children's Medical Center
282 Washington Street
Hartford, Connecticut 06106
Attn: Legal Department

To HOCC:
The Hospital of Central Connecticut
100 Grand Street
New Britain, CT 06050
Attn: Vice President, Medical Affairs

(c) The parties agree to conform to applicable laws and/or regulations, including the applicable requirements of EMTALA, and to use commercially reasonable efforts to preserve their respective tax exempt status under Section 501(c)(3) of the Internal Revenue Code, without terminating this Agreement.

(d) If any provision of this Agreement is determined by final decision of an administrative agency or court (after exhaustion of appeals or appeal rights) to be invalid or in violation of any law or regulation, such provision shall be severed from this Agreement and the remainder of this Agreement shall be given effect by the parties as if such provision never had been part of this Agreement. Any provision of this Agreement that is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining provisions of this Agreement or affecting the validity or enforceability of such provision in any other jurisdiction.

(e) The parties agree that the relationship hereunder is that of independent contractors. This Agreement is not intended and shall not be construed to make either party a principal, an agent or a joint venturer with the other party. Each party expressly disclaims any intention to enter into such agency or joint venture and agrees that it will conduct its activities hereunder so as not to act or purport to act on behalf of the other party.

(f) Each party shall be solely responsible for billing and collecting charges that result from services it has rendered pursuant to this Agreement. Each party will promptly provide the other party with all appropriate information pertinent to third party reimbursement. Neither party assumes nor shall have any liability to the other for such charges, except to the extent such liability exists separate and apart from this Agreement.

(g) Nothing contained in this Agreement is intended to nor shall be construed to create any third party rights for a patient or any other person or entity not a party to this Agreement.

(h) This Agreement shall be construed and all of the rights, powers and liabilities of the parties shall be determined in accordance with the laws of the State of Connecticut.

(i) This Agreement contains the whole understanding of the parties and supersedes all prior oral or written representations and agreements between the parties and any of their representatives or staff as to the subject matter of this Agreement, and may not be varied except in a writing executed by the parties.

(j) This Agreement may not be assigned by either party without the prior written consent of the other party, except that upon advance written notice to the other party either party may assign this Agreement to a successor corporation that carries on all or substantially all of its business. Subject to the foregoing limitation upon assignment, this Agreement shall be binding upon and inure to the benefit of the successors and assigns of the parties.

(k) Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other institution on either a limited or general basis while this Agreement is in effect.

(l) This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date first written above.

Connecticut Children's Medical Center

By: _____
Its: SENIOR VP & CFO
Date: 6/11/15

The Hospital of Central Connecticut

By: _____
Its: VP Finance
Date: June 9, 2015

Exhibit 5

The Hospital of Central Connecticut
A Hartford HealthCare Partner

June 1, 2015

Janet Brancifort
Deputy Commissioner
OHCA

Dear Ms. Brancifort:

I appreciate the opportunity to write in support of The Hospital of Central Connecticut's request to transition inpatient and outpatient pediatric services to providers in our community and region. I have had the pleasure of serving as the Chief of Pediatrics at HOCC for the past year and as the medical director of Newborn Care for the year prior. I have been practicing in Connecticut since 2002 and I have seen monumental changes in our health care system over time. The decreased utilization of pediatric inpatient services has been marked over the last 20 years, not only in New Britain, but throughout our country. Our victories in treating vaccine-preventable illnesses as well as advances in care for conditions such as asthma, diabetes and prematurity have shifted much of our treatment to the outpatient arena. The majority of children requiring inpatient care are now our most complicated of cases often requiring the input of subspecialists and availability of testing modalities outside the scope of a community pediatric inpatient program. Therefore, it is not surprising that our pediatric admissions have steadily declined due to parent or provider preference and the need for more comprehensive and specialized services. In addition, due to our limited volume, we are unable to provide the ancillary services available in a tertiary care children's hospital such as child life services and pediatric focused therapists. It has become a challenge to maintain the nursing skill set for pediatrics that hospitalized children deserve.

The closing of our inpatient pediatric services will not affect our ability or willingness to care for any child presenting to our Emergency Department. We will collaborate with Connecticut Children's Medical Center (CCMC) to appropriately stabilize and safely transfer children requiring inpatient care outside of the capability of our newborn unit. We have an excellent group of neonatologists, community pediatricians and pediatric physician assistants who provide routine and critical care services to newborns in our Family BirthPlace and Neonatal ICU and we will continue to focus on these strengths in our inpatient program.

The HOCC has a long history of providing a medical home for routine outpatient pediatric care to children in our community. Over the years, the number of patients we serve as well as the number of pediatricians available to care for those patients has decreased. In addition, the community we serve requires routine medical care plus other supportive care that is not available within our program. The Community Health Center (CHC) of New Britain is a federally qualified health center within our community that offers a wide range of services including behavioral health, school based services, and dentistry as well as medical care, and is able to offer expanded hours to better meet the needs of patients. We have been in discussion with their leadership to provide a smooth transition of care to our patients who wish to choose CHC

as their medical provider. The patients we currently serve in the pediatric clinic will have their choice of several community pediatric providers, of which CHC is only one option , but provides a wide range of services to best meet our patients' needs.

We are charged with continually evaluating how to provide safe, high-quality, cost-efficient care to all we serve and the decision to transition these services has been taken very seriously with the ultimate intent to offer the highest level of care to our patients and for the communities we serve.

Sincerely,

Annmarie Golioto, MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics

Hartford HealthCare

The Hospital of Central CT
100 Grand Street
New Britain, CT 06050
Office 860-224-5011 x 4155
Fax 860-224-5795
Annmarie.golioto@hhchealth.org

www.hartfordhealthcare.org
www.thocc.org

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Patel,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, Alpa Patel M.D., am interested in and have capacity to accept new pediatric patients into my practice

_____ signed by acknowledged physician, practice in Plantsville, CT

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Blumer,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, Arthur Blumer M.D., am interested in and have capacity to accept new pediatric patients into my practice

BLUMER signed by acknowledged physician, Personal Care Pediatrics in Southington, CT

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Lopreiato,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, Matteo Lopreiato M.D., am interested in and have capacity to accept new pediatric patients into my practice

_____ signed by acknowledged physician, Berlin Pediatric Associates, Berlin, CT

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Adenyinka,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, Susan Adenyinka M.D., am interested in and have capacity to accept new pediatric patients into my practice

_____ signed by acknowledged physician, Pediatric Care Center in Bristol, CT

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Szajda,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, Teresa Szajda M.D., am interested in and have capacity to accept new pediatric patients into my practice

_____ signed by acknowledged physician, practice in Plainville, CT

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Peterson,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, Mark Peterson M.D., am interested in and have capacity to accept new pediatric patients into my practice

signed By acknowledged physician, practice in Southington, CT

The Hospital of Central Connecticut
Connect to healthier.™

July 6, 2015

Dear Dr. Skarvinko,

At The Hospital of Central Connecticut, we must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. As you are aware, after careful consideration, The Hospital of Central Connecticut will be terminating the provision of inpatient and outpatient pediatric services and transitioning these services to providers within the New Britain community. These changes require regulatory approval and will take place over a period of time once regulatory approval is obtained.

Current arrangements will continue with Connecticut Children's Medical Center (Connecticut Children's) as our partner for inpatient care. We would like to work with our community pediatric providers including the Community Health Center of New Britain and community pediatricians like yourself, to ensure that our pediatric patients, have a smooth transition to a pediatric medical home in the New Britain community.

As a trusted and respected member of the New Britain pediatric community, it is our privilege to ask for your involvement in expanding the care you provide to our pediatric population by accepting new patients into your practice.

As a demonstration of your interest in and ability to accommodate new patients, please sign the acknowledgement below which will be included in the information provided during the regulatory approval process.

The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans

Sincerely,

Annmarie Golioto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

I, George Skarvinko, M.D., am interested in and have capacity to accept new pediatric patients into my practice

_____signed by acknowledged physician, practice of Southington Pediatric Associates, Southington, CT

Connecticut Children's
MEDICAL CENTER

July 14, 2015

Deputy Commissioner Janet Brancifort
Department of Public Health
Office of Health Care Access
P.O. Box 340308
Hartford, CT 06134

Re: Letter of Support for HOCC Termination of Pediatric Inpatient Services

Dear Commissioner Brancifort,

I am writing this letter in support of The Hospital of Central Connecticut's (HOCC) application for the termination of pediatric inpatient services.

The national landscape for providing specialized healthcare has changed dramatically, enabling and requiring organizations to partner in order to provide higher quality, cost-effective care. To that end and, after much thoughtful consideration, HOCC has determined that their pediatric patients who require hospitalizations would be most appropriately cared for at Connecticut Children's Medical Center (Connecticut Children's). Our two institutions have experienced a long-standing, successful partnership. This is the next step in our evolving collaboration to better care for the communities we serve.

Connecticut Children's has been named among the best for its pediatric care by *U.S. News & World Report* and is the only free-standing children's hospital in the state. We offer a broad array of pediatric services that includes pediatric medical and surgical subspecialists, pediatric radiology specialists, and ancillary services specific to pediatric care such as physical, occupational, and speech therapy as well as child life specialists, all in a pediatric-friendly environment best suited to this population. We look forward to serving patients in the HOCC community and we welcome the opportunity to grow our partnership.

If you have any questions, please feel free to contact me.

Sincerely,

Martin J. Gavin
President and CEO

Administrative:
635 Main Street
Middletown, CT 06457
860.347.6971

Locations:

CHC of Bristol
395 North Main Street
Bristol, CT 06010
860.585.5000

CHC of Clinton
114 East Main Street
Clinton, CT 06413
860.664.0787

CHC of Danbury
8 Delay Street
Danbury, CT 06810
203.797.8330

CHC of Enfield
5 North Main Street
Enfield, CT 06082
860.253.9024

CHC of Groton
481 Gold Star Highway
Groton, CT 06340
860.446.8858

CHC of Meriden
134 State Street
Meriden, CT 06450
203.237.2229

CHC of Middletown
675 Main Street
Middletown, CT 06457
860.347.6971

CHC of New Britain
85 Lafayette Street
New Britain, CT 06051
860.224.3642

CHC of New London
One Shaw's Cove
New London, CT 06320
860.447.8304

CHC of Old Saybrook
263 Main Street
Old Saybrook, CT 06475
860.388.4433

CHC of Waterbury
51 North Elm Street
Waterbury, CT 06702
203.574.4000

Day Street CHC
49 Day Street
Norwalk, CT 06854
203.854.9292

Franklin Street CHC
141 Franklin Street
Stamford, CT 06901
203.969.0802

www.chc1.com
Facebook/CHCInc
Twitter(@CHCConnecticut)

Where health care is a right, not a privilege, since 1972.
Community Health Center, Inc.

8/28/2015

Lucille Janatka
President and CEO
Hospital of Central Connecticut
New Britain, CT 06050

On behalf of the Community Health Center, I am pleased to provide the Community Health Center's support for your Certificate of Need application to end your pediatric inpatient and outpatient services at the Hospital of Central Connecticut. As part of this agreement the Community Health Center Inc. is happy to accept those patients who choose to transfer to the Community Health Center of New Britain at 85 Lafayette Street for their pediatric primary care.

As you know, the Community Health Center has a strong patient centered medical home model of care and we are committed to caring for the vulnerable children of New Britain. We appreciate your thoughtful work in reaching the decision to terminate the services and believe you have developed an effective transition plan to ensure that all of the health care needs of the pediatric population which are currently being met at the Hospital of Central Connecticut will continue to be met in the future.

Sincerely,

Margaret Flinter
Sr. VP / Clinical Director
Community Health Center, Inc
635 Main Street
Middletown, CT 06457

The Hospital of Central Connecticut
A Hartford HealthCare Partner

August 27, 2015

Margaret Flinter, APRN, PhD
Senior Vice President and Clinical Director
Community Health Center, Inc.
635 Main Street
Middletown, CT 06457

Re: HOCC's Proposed Termination of Outpatient Pediatric Services

Dear Margaret:

As we recently discussed, the Hospital of Central Connecticut ("HOCC") is proposing to terminate its inpatient and outpatient pediatric programs because of historical underutilization. HOCC would like to offer your organization with assistance to ensure an orderly and timely transition of our pediatric patients should they choose Community Health Center of New Britain ("CHC-NB") located at 85 Lafayette Street in New Britain as their provider of choice. Specifically, HOCC proposes that it would fund the salary and benefit expenses of a pediatrician or pediatric nurse practitioner, the choice to be determined by CHC, with pediatric competencies for a period of one year. If you agree with this letter, a more comprehensive letter of agreement will be prepared by HOCC for your future signature.

In the meantime, if you agree with this letter, please indicate your acceptance by signing below. We greatly appreciate your collaboration and willingness to coordinate in the delivery of pediatric services to our community.

Sincerely,

Lucille Janatka
President and CEO

ACCEPTED AND AGREED:

Margaret Flinter, APRN, PhD
Senior Vice President and Clinical Director
Community Health Center, Inc.

Date: 8/28/2015

Exhibit 6

THE HOSPITAL OF CENTRAL CONNECTICUT (HOCC)
PEDIATRIC CLINIC
TRANSITION OF CARE PLAN

Concurrent with notification of intent to file CON:

An interdisciplinary team [made up of who] was convened to develop and implement a comprehensive transition of care plan to assure an uninterrupted care continuum for all of the pediatric patients comprising HOCC's clinic panel. Essential components of the plan are identified below.

- An initial communication cascade, internal to HOCC, was prepared and distributed to inform all affected individuals within HOCC of the intent to transition pediatric care. There was/will be special emphasis on sequenced communications to staff, keeping all staff well-informed, and by extension keeping our patients appropriately informed during all clinic interactions.

- The team compiled an inclusive list of current pediatric clinic patients, whose care would be transitioned.

- Communications with alternative care providers who have agreed to assume our patients will be secured.

Contingent on CON Approval:

A bilingual (English/Spanish) patient communication (draft attached) will be sent to all active pediatric clinic patients. It will inform patients that we will continue to serve them in the pediatric clinic for an additional 6 months post CON-approval while assisting them with the process for transition of care. We anticipate that the document will include guidance regarding remaining with their current pediatric provider at a new location in New Britain and the option to transfer care to other accepting providers in New Britain and the surrounding communities. Communication will also include direction for items such as requests for medical records. This process will also be reviewed in person with each family presenting at the clinic and by phone for families calling for appointments or assistance during the interval between CON approval and final day of clinic operations.

Regarding medical records; they will be available for immediate release without charge, when requested directly by the patient (parent for minors) or from the patient's designated new care provider. Medical records will remain in the current clinic location in order to facilitate ease of access, and will be maintained locally for at least one year prior to transfer to long term storage.

A kiosk with bilingual signage will be displayed in the clinic waiting room regarding planned termination of clinic operations. It will include information to facilitate the stepwise process of selecting and transitioning to a new pediatric provider.

New patients will no longer be accepted into the HOCC pediatric clinic practice. Existing patients will be scheduled up to the final day of clinic operations.

All patients with prescheduled appointments, beyond the final day of clinic operations, will be contacted by phone well in advance to reschedule their appointment sooner, if appropriate, and/or to communicate the transition plan and assist in identifying a new provider.

We anticipate the final day of operations occurring 6 months post CON-approval. We will continue to assist patients in transitioning care to alternative providers by phone, up to one year after the final day of clinic operations. During the initial 60 days following the final operations day, a special dedicated telephone line will be operational to provide this assistance. Following this 60-day period, patients will be assisted by the medical clinic staff during business hours and in the HOCC emergency department

For after-hours, specific patient care questions following the clinic final day of operations, HOCC operators will direct patients to call their new provider. If a new provider has not yet been identified, the patient will be advised to proceed to the HOCC emergency department (if care is required outside of normal business hours) and follow up with the clinic staff the next business day for assistance in identifying a new provider.

Consistent with our current practice, we will continue to see all pediatric patients presenting to our emergency room. Our ED staff will evaluate, treat and discharge the majority of patients. If either the ED physician or primary care physician deems inpatient care outside the scope of HOCC to be necessary, then the patient will be transferred to CCMC for specialty care in accordance with our transfer agreement between CCMC and HOCC.

Exhibit 7

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0052

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Hospital of Central Connecticut at New Britain General and Bradley Memorial of New Britain, CT d/b/a The Hospital of Central Connecticut is hereby licensed to maintain and operate a General Hospital.

The Hospital of Central Connecticut is located at 100 Grand Street, New Britain, CT 06052-2008.

The maximum number of beds shall not exceed at any time:

32 Bassinets
414 General Hospital Beds

This license expires **December 31, 2016** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, January 1, 2015.

Satellites:

Hispanic Counseling Center, 73 Cedar Street, New Britain, CT
The Hospital of Central Connecticut at Bradley Memorial, 81 Meriden Ave., Southington, CT
Outpatient Psychiatry and Behavioral Health, 73 Cedar Street, New Britain, CT
*Hartford Healthcare Cancer Institute at the Hospital of Central CT, 183 North Mountain Road, New Britain, CT

License revised to reflect:
*Added (1) Satellite effective 3/16/15

Jewel Mullen, MD, MPH, MPA
Commissioner

Exhibit 8

Lucille Janatka is Hartford HealthCare senior vice president and president of the Hartford HealthCare Central Region, which includes MidState Medical Center in Meriden, Conn., and The Hospital of Central Connecticut with its Bradley Memorial campus in Southington and its New Britain campus.

MidState, a 144-bed hospital, consistently ranks among the top hospitals in the state and nation in quarterly patient satisfaction surveys. Among its numerous awards and distinctions, MidState was named among Solucient's 100 Top U.S. Hospitals for intensive-care services; received the Press Ganey "Best of the Best" Award for the top 25 hospitals in the United States; earned the Healthgrades Outstanding Patient Experience Award; and was named one of the Best Small and Medium Companies to Work for in America by the Great Place to Work Institute.

The Hospital of Central Connecticut is a 414-bed teaching hospital that was the first in New England to be a founding member of the WomenHeart National Hospital Alliance and was first in the state to be recognized as a Certified Quality Breast Center of Excellence. Among its many honors, the hospital also received the American Heart Association Fit Friendly Work Site Award for employee wellness programs and the 2012 Wellness Council of America Well-Workplace Award.

Ms. Janatka was named to her current position in September 2013. Previously, she served as president and CEO of MidState Medical Center. Before joining MidState in 1999, Ms. Janatka served as chief operating officer of Waterbury Hospital; vice president of operations at The Hospital of St. Raphael; vice president of administration for Greenwich Hospital; and senior vice president of Meriden-Wallingford Hospital, the predecessor of MidState.

Ms. Janatka is a fellow in the American College of Healthcare Executives. She has received numerous awards, including the Community Partnership Award from the Meriden Chamber of Commerce, the Women in Business Award from the *Hartford Business Journal*, the Special Recognition Award from the Connecticut Women's Hall of Fame, the Athena Award from the Quinnipiac Chamber of Commerce, the Regent's Award from the American College of Healthcare Executives and the Strong, Smart and Bold Award from Girls Inc. of Meriden. She was recognized by the Connecticut Women's Hall of Fame for her business management, administration and leadership in health care and was among the Top 25 Women in Healthcare named by *Modern Healthcare Magazine*.

Ms. Janatka holds a Master of Science in nursing administration from Boston College and a Bachelor of Science in nursing from St. Anselm College.

Hartford HealthCare is Connecticut's only truly integrated health care system. With more than 18,000 employees and $2.4 billion in net revenue, the system offers the full continuum of care with five-acute care hospitals, a state-wide air-ambulance service, behavioral health and rehabilitation services, a large physician group and clinical integration organization, skilled-nursing and visiting-nurse services, a laboratory system that spans the state, and a number of services for seniors, including senior living facilities.

Annmarie Golioto, MD, FAAP
Hospital of Central CT
100 Grand Street
New Britain, CT 06050
annmarie.golioto@hhchealth.org
860-224-5011 x 4155
Fax 860-224-5795

Academic and Hospital Appointments

4/11/14-present	Chief of Pediatrics Attending Neonatologist Director of Nurseries Department of Pediatrics The Hospital of Central Connecticut New Britain, CT
8/1/13-4/11/14	Attending Neonatologist Director of Nurseries Department of Pediatrics The Hospital of Central Connecticut New Britain, CT
9/12-8/13	Attending Neonatologist-Northeast Medical Group Medical Director, Newborn ICU and Newborn Service Yale New Haven Hospital-Saint Raphael's Campus, New Haven, CT
6/06-9/12	Attending Neonatologist Medical Director, Newborn ICU and Newborn Service Department of Women's and Children's Services Hospital of St Raphael, New Haven, CT
6/06-present	Assistant Clinical Professor of Pediatrics Attending Neonatologist Division of Neonatal-Perinatal Medicine Department of Pediatrics Yale University School of Medicine, New Haven, CT
7/02- 6/06	Assistant Professor of Pediatrics Attending Neonatologist Division of Neonatal-Perinatal Medicine Department of Pediatrics Yale University School of Medicine, New Haven, CT

	Medical Director, Newborn ICU and Newborn Service Hospital of Saint Raphael, New Haven CT

Leadership Education:

9/2014-6/2015	Physician Leadership Development Institute Hartford Healthcare
6/2014-present	American Association for Physician Leadership, Member
9/2013	High Reliability Organization Training
1/2012-6/2013	LifeWings Team Training Course and Committee Member

Medical Training

7/99-6/02	Neonatology Fellowship Duke University Medical Center, Durham, NC
7/96-6/99	Pediatric Internship and Residency Duke University Medical Center, Durham, NC

Medical Education

8/92-5/96	University of Medicine and Dentistry of NJ, New Jersey Medical School, Newark, NJ
Degree:	M.D., May 1996
Honors:	American Medical Woman's Association Janet M. Glasgow Memorial Achievement Citation Award Alpha Omega Alpha Medical Honor Society Dean's Commendation for Academic Excellence Student Summer Research Scholar

Undergraduate Education

8/88-5/92	Emory University, Atlanta, GA
Degrees:	B.S. Biology, May 1992 B.A. Religious Studies, May 1992

Licensure

Connecticut Medical License # 040188-current through June 30, 2016
DEA# BG7659266 Expires 9/30/2016
CT Dept of Consumer Protection License # CSP0031979 Expires 2/28/2016

Certifications/Awards

The Mill Foundation for Kids Above and Beyond Award, March 2015
Board Certified, Neonatal-Perinatal Medicine, initial November 2003; MOC current
Board Certified in Pediatrics, initial October 1999; MOC current
Neonatal Resuscitation Program Regional Trainer, 2003-present
Fellow of the American Academy of Pediatrics, 7/02-present
ECMO Provider, Yale-NHH-Neonatal Intensive Care Unit, 7/2002-present
Training Course, September 2001, Children's National Med Center, Washington, DC
Trainer, The Secrets of Baby Behavior Course, from Univ of CA Davis Lactation Center, September 2013

Professional Organizations:

CT State Medical Society
AAP-CT State Member
AAP-Section on Perinatal Pediatrics
Fellow of the American Academy of Pediatrics
Alpha Omega Alpha Medical Honor Society
American Association for Physician Leadership

Committees and Quality Projects

THOCC Quality and Safety Women's and Infant's Committee
May 2015-present
Hartford Healthcare Obstetrics Council and Newborn SubCouncil
September 2014-present
THOCC Women's and Infant's Steering Committee
August 2014-present
THOCC Senior Executive Committee
April 2014-present
THOCC Physician Leadership Committee
April 2014-present
THOCC Quality Assessment and Performance Improvement Committee
April 2014-present
Hartford HealthCare Care Connect Team Member
Building EPIC system
January 2014-present
THOCC H3W (How Hartford Healthcare Works) Work Group Leader
August 2013-present
THOCC Lactation Services Council

Aug 2013-present
Led team to successful Baby Friendly® Designation August 2014
THOCC Newborn Operations Council
Aug 2013-present
THOCC Pharmacy and Therapeutics Committee
August 2013-present
THOCC Team Leader Vermont Oxford Neonatal Database
August 2013-present
THOCC, Pediatrics Peer Review
August 2013- present
Yale NNICU Breastfeeding Committee,
March 2012-July 2013
Chairperson, Baby Friendly Hospital Initiative Committee
October 2009-July 2013
Hospital of Saint Raphael-Led team to successful Baby Friendly® designation November 2011
Leadership Committee 2008-2013
Department of Women's and Children's Services
Hospital of Saint Raphael
Lifewings Steering committee 2011-2013
Department of Women's and Children's Services
Hospital of Saint Raphael
Quality Improvement and Practice Council 2008-2013
Department of Women's and Children's Services
Hospital of Saint Raphael
Peer Review Committee 2006-2013
Department of Women's and Children's Services
Hospital of Saint Raphael
Representative. CT Department of Public Health for the Vaccines for Children Program, Hospital of Saint Raphael 2002-2012
Infection Control Committee 2002-2013
Hospital of Saint Raphael
Pharmacy and Therapeutics Committee 2002-2013
Hospital of Saint Raphael

Media Appearances:

WFSB, March 30, 2015
http://www.wfsb.com/story/28655507/bristol-family-wants-to-help-hospital-that-saved-twins

The New Britain Herald, May 5, 2014
"HEALTHY LIVING: Breast feeding babies has many benefits"

Connecticut Style-News Channel 8 TV, February 2012
"The Vidone Birth Center at the Hospital of Saint Raphael"

New Haven Register-February 2012
"Hospital of St. Raphael earns baby-friendly honor"

New Haven Register-January 2010
"Oh, Baby: Robotic newborn helps train doctors, nurses at St. Raphael"

Webinars:

Faculty Participant, March of Dimes Webinar, June 19, 2012
"Pulse Oximetry Screening for Critical Congenital Heart Disease"

Moderator, CTAAP Teleconference, February 24, 2012
"The Role of the Pediatrician in the Baby Friendly Hospital Initiative"

Grants

11/2011	Connecticut Health and Educational Facilities Authority $75,000: To support BABY program: post-discharge Breastfeeding support as part of Baby Friendly Hospital Initiative
9/2010	New Alliance Bank Foundation $15,000 To support Baby Friendly Hospital Initiative
9/2009	Lukan Indemnity Grant $30,000 To support Neonatal Resuscitation Program Training with simulated newborn
7/99-6/01	National Institutes of Health, National Research Service Award HL-07538

Protocol Development :

Circumcision Guideline
Early Onset Sepsis
Hypoglycemia in the Newborn
Safe Sleep in the Newborn
Newborn Nursery Standard Care Guideline
Apgar Scoring Procedure
Assisted Mechanical Ventilation Protocol-Neonatal
Blood Pressure Monitoring-Neonatal-Procedure
Blood Products Administration-Neonatal Procedure
Breastfeeding Protocol
Cardiac ECHO-Neonatal Procedure
Cardio-Respiratory Monitoring-Neonatal
Chest Tube Management-Neonatal
Chest Tube Procedure-Neonatal
Circumcised Newborn Management
Circumcision Procedures
CPAP Application Procedure
CPAP Neonatal Protocol
Endotracheal Suctioning-In line-Neonatal

Endotracheal Suctioning-Open-Neonatal
Formula and fortifier preparation
Gavage Feeding Protocol and Procedure
Heel Puncture-Neonatal
Genitourinary Tube Placement-Neonatal
HIV Management-Neonatal
Hyperbilirubinemia-Neonatal Management
Identification and Security of Newborn Protocol
Intraosseous Insertion and Infusion-Neonatal
Intravenous Device-Neonatal Procedure
Intravenous Therapy-Neonatal Protocol
Late Preterm Infant Protocol
Metabolic Screening-Neonatal Procedure
Mechanical Ventilation-Neonatal Protocol
Newborn Intensive Care Management Protocol
Newborn Management in Delivery Suite Protocol
Normal Newborn Management Protocol
Oxygen Therapy-Neonatal Protocol
Phlebotomy-Neonatal Procedure
Phototherapy-Neonatal Procedure
PICC Line-Neonatal Procedure
Pneumothorax, Needle Aspiration-Neonatal Procure
Pulse Oximeter Monitoring-Neonatal Procedure
Pulse Oximetry CCHD Newborn Screening Protocol
Sepsis, early onset-Neonatal protocol
Spinal Tap, Neonatal Procedure
Suprapubic Tap of Bladder-Neonatal procedure
Thermoregulation-Neonatal Procedure
Thermoregulation-Neonatal protocol
Transfer of Neonate to Tertiary care Procedure
Transillumination of Chest-Neonatal Procedure
Umbilical Catheter Protocol
Umbilical Catheter Procedure
Visiting Mother off Unit-Neonatal Procedure

Teaching/Lecture Highlights:

Pediatric Grand Rounds, Bridgeport Hospital
"The Pediatrician and the Baby-Friendly Hospital Initiative" 2/2013

Department of Women's and Children's Services-HSR
Leadership Development Group
"Communicating Effectively" 12/2011

Pediatric Grand Rounds, Hospital of Saint Raphael
Neonatal Hypoglycemia 10/2010
Baby Friendly Hospital Initiative 9/2010
Respiratory Distress Syndrome, 5/2009
Neonatal Nutrition 2/2009

Necrotizing Enterocolitis 1/2009
Intrauterine Growth Retardation 9/2008
Neonatal Herpes Simplex Virus 10/2008
Neonatal Hypotonia, 6/2008
Meconium Aspiration Syndrome 5/2008
Neonatal Respiratory Diseases 1/2008
Kernicterus 12/2007
Neonatal stroke 6/2007
Neonatal Infections 2/2007
Resuscitation at the Limits of Viability 1/2006

OB/GYN Grand Rounds, Hospital of Saint Raphael
The Late Preterm Infant 10/2011
Baby Friendly Hospital Initiative 10/2010
Meconium Aspiration Syndrome 5/2008
Resuscitation at the Limits of Viability 1/2006

Yale NNICU ECMO Seminar May 2009
"Decannulation"

CT Society for Respiratory Care Super Symposium XXVII, May 6, 2009
"Neonatal Respiratory Distress Syndrome"

Abstracts and Presentations

Kalinchak, Jillian, Morelli, Erin and Annmarie Golioto: SRHS-IRB Protocol #SR-1755 Group B Strep Guideline Compliance and Neonatal Outcomes in One Midwife Practice, Approval Date 2/2010

Golioto, A and JR Wright. Survanta® and Surfactant–Like Liposomes Inhibit Innate and Surfactant Protein A Mediated Host Defense Functions in Alveolar Macrophages. Poster presentation, Department of Pediatrics Fellow's Symposium, Durham, NC, May 2001; Poster presentation, Society for Pediatric Research Meeting, Baltimore, MD, April 2001; Platform presentation, Southeastern Conference on Perinatal Research, Key Largo, FL, February 2001.

Golioto, A and JR Wright. Phagocytosis of *Streptococcus pneumoniae* by Rat Alveolar Macrophages is Inhibited in the Presence of Survanta® and Surfactant Lipids. Perinatal and Developmental Medicine Symposium, Marco Island, FL, November 2000.

Auten, RL, Mason, SN, Richardson, RM, Vozzelli, M, Golioto, A, White, JR. CXCR2 Receptor Blockade with Competitive Antagonist SK 265610 (SK) Prevents Hyperoxia Induced Neutrophil Accumulation in Newborn Rat Lung. Platform presentation, Society for Pediatric Research and American Academy of Pediatrics Joint Meeting, Boston, MA, May 2000.

Golioto, A and JR Wright. The Effect of Survanta® on the Phagocytosis of *S. pneumoniae* by Alveolar Macrophages. Platform presentation, Southeastern Conference on Perinatal Research, Key Largo, FL, March 2000.

Lavery, RF, Tortella, BJ, Panarotto, A, Leibowitz, E. Epinephrine Versus Albuterol in the Prehospital Treatment of Pediatric Asthma. Journal of Emergency Medical Services, March, 1995. Poster presentation, Annual Emergency Medical Services Today Conference, 1995.

Publications

Golioto, A. Group B Streptococcus continues to threaten neonates. The Yale-New Haven Children's Hospital Physician Letter. 9(3): 3-4, September 2003.

Milazzo, AS, Golioto, A, Camitta, MGW, O'Laughlin, MP. Case report: an infant with subvalvar and valvar aortic stenosis, subvalvar and valvar pulmonary stenosis, severe biventricular hypertrophy and pulmonary hemorrhage. *Pediatric Cardiology* 2003; 24: 169-171.

Golioto, A and JR Wright. Effects of Surfactant Lipids and Surfactant Protein A on Host Defense Functions of Rat Alveolar Macrophages. *Pediatric Research*, 51(2): 220-227, February 2002.

Personal

Birthdate: 6/8/70
Birthplace: Hackensack, NJ, USA
Maiden Name: Annmarie Panarotto
Married: 5/24/97
Husband: Michael, CT Gastroenterology, Hartford, CT
Children: Alexandra Rose, 10/29/02; John Matthew 4/16/05; Lauren Anna 5/24/07
Address: 30 Sherwood Lane Cheshire, CT 06410
Cell: (203) 605-5420
Personal email: amgolioto@cox.net

Catherine W. Stevens, RN, MSN-OD
7 Ash Creek Road Branford, CT 06405
Cell: (203) 859-0245 catherine.stevens@hhchealth.org

Professional Experience

Hartford Healthcare Corporation (HHC) Sept 2014-present
Epic Implementation and Care Transformation
Senior Nurse Executive

- System nurse executive working with HHC CareConnect team (Epic implementation) to design and implement clinical care transformation and Epic electronic health record across the health system

The Hospital of Central Connecticut Nov 2013- present
Vice President, Patient Care Services

- Responsible for patient care services, nursing, and nursing practice in 414-bed acute care hospital

MidState Medical Center Feb 2011 – Present
Vice President, Patient Care Services
Chief Nursing Officer

- Responsible for the delivery of high quality, safe patient care services in 144 bed acute care hospital
- Organizational responsibility for safety and quality
- Patient care responsibilities include medicine, surgery, critical care, oncology, emergency services, case management, laboratory services and hospitalist service

Yale New Haven Hospital Nov 2006 – Jan 2011
Director of Patient Services-Women and Infants'

Nursing and operational leader of comprehensive obstetrical and well newborn service including: labor and birth unit (4700 deliveries and 6,000 triage visits per year), ante partum and post partum units, outpatient maternal fetal medicine practice sites (24,000 patient visits/year), and the Women's Education and Lifelong Learning (WELL) program. Management of $20 million operating budget.

Select service line accomplishments:

- Led interdisciplinary and multidimensional OB team dedicated to the delivery of the highest level of safe care resulting in decreased OB adverse outcomes index (AOI) 2.96 to 1.96, hand hygiene compliance scores > 92% for 3 consecutive quarters, development of Obstetrical simulation program, and provision of OR standardization
- Created new nursing team leading to increase in employee opinion scores averaging 0.73 per patient care unit (4.0 scale), decrease in vacancy rate from 10% to 0%, and reduction in turnover from 19% to 11%
- Led site implementation in multisite CT newborn data registry as mandated by CT Department of Public Health
- Opened newly renovated Labor and Birth Triage Unit

Select organizational contributions:

- Provided leadership for development of YNHH nursing website as a means of communication and collaboration for Registered Nurses across the organization
- Editor, Nursing Update 2007- present

Yale New Haven Hospital May 2010 – Jan 2011
Director, Centralized Staffing and Scheduling Department (CSSD)

Operational leader for newly developed CSSD division: department's responsibilities include assumption of schedule creation and payroll management for 35 inpatient care units; management and deployment of >250 RN and ancillary staff in CSSD division; and over sight of staffing 24/7 for 966 bed hospital.

Yale New Haven Hospital Dec 2007 – Jul 2010
Director, Off-Shift Administrators

Led team of administrators responsible for organizational oversight during the evenings, nights, and weekends. Responsibilities include staffing, patient flow, emergency response, and liaison to the administrator on call. Collaborated with external consultant to develop new role, operationalized by the off-shift administrators, to improve patient throughput and efficiency.

Yale New Haven Hospital Jun 2008 – Dec 2008
Director of Patient Services – Medicine (interim)

In addition to role as Director of Patient Services – Women and Infants assumed role as interim Director of Patient Services – Medicine while the position was vacant. Responsible for leadership of six general inpatient units and two medical intensive care units.

Yale New Haven Hospital Jun 2000 – Nov 2006
Manager – Pediatric Intensive Care Unit

Managed daily operation of a 19 bed interdisciplinary pediatric intensive care providing care for critically ill patients ranging in age from newborn to adult with medical, surgical, cardiovascular, oncology, and trauma related illness and injury. Organizational responsibilities included clinical oversight, human resources management, budgetary management, safety and quality improvement, and services excellence leadership.

Select accomplishments:

- Led renovation project increasing PICU from 11 to 19 beds including redesign of the environment to support a family centered model of care
- Transformed PICU culture by leading, developing, and implementing a family centered model of care including participation of parents in patient care rounds, parents sleeping at bedside, and parental presence during codes, emergencies, and procedures.

Yale New Haven Hospital Aug 1995 – Jun 2000
Clinical Nurse IV – Pediatric Intensive Care Unit

- Clinical leader in the care of critically ill medical and surgical pediatric patients

Yale New Haven Hospital Jun 1991 – Apr 1995
Clinical Nurse IV – Pediatric Adolescent Unit

- Clinical leader in the care of pediatric oncology patients

Yale New Haven Hospital Apr 1988 – Jun 1991
Assistant Nurse Manager – Pediatric Adolescent Unit

- Chemotherapy certified
- Led interdisciplinary team in development of policies and protocols for first pediatric autologous bone marrow transplant

Yale New Haven Hospital Jun 1986 – Apr 1988
Staff Nurse – Pediatric Adolescent Unit

Education

Registered Nurse, State of CT	1986 – present
Doctorate of Nursing Practice (enrolled)	2012-present (2015 anticipated graduation)
Sacred Heart University	
Master of Science in Nursing and Organization Development	June 2004
University of Hartford, GPA 3.93	
Bachelor of Science in Nursing	May 1986
Fairfield University, GPA 3.6	

Current Professional Affiliations

Association of Nurse Executives
Organization of Nurse Executives – CT
American College of Healthcare Executives
American Society of Professionals in Patient Safety

Community Volunteer Roles and Board Membership

Spanish Community of Wallingford Board, member	2012-2014
Organization of Nurse Executives-CT, president	2013-present
Organization of Nurse Executives-CT, president elect	2012-2013
Organization of Nurse Executives-CT, Treasurer	2010-2012
Xavier High School, Home School Board, member	2007 – 2009
Saint Mary Church, lector	2007 – present
Ronald McDonald House, Board of Directors member	2004 – 2007
Girl Scouts of America, volunteer	2006 – 2008
Boy Scouts of America, volunteer	2003 – 2006

National Certification

Certified Professional in Patient Safety	2012-present
Nurse Executive, Advanced-Board Certified	2012-present
Critical Care Certification (CCRN, Pediatrics)	1997 – 2000

Professional Recognition

Excellent Nurse Manager Award, American Association of Critical Care Nurses, 2005
Leadership in Community of Scholarly Caring Award, University of Hartford, Hartford, CT, 2004
Excellence in Management Award, Yale New Haven Hospital, 2004
Forty Under 40 Recognition of Professional Achievement and Community Involvement, New Haven Business Times, 2002
Elizabeth Dolan Award, Fairfield University, 1986

NANCY M. KROEBER

SUMMARY

Health Care Leader with progressive responsibility and proven ability for developing successful programs and services, fostering teams that consistently exceed standards and building partnerships with physicians and staff that drive growth, financial performance and operational excellence.

STRENGTHS

Program Development	Teambuilding
Business Acumen	Employee Mentoring and Development
Change Management	Performance Improvement
Work System Design	Principle Centered Leadership

EMPLOYEMENT HISTORY

THE HOSPITAL OF CONNECTICUT, NEW BRITAIN CT *(Formerly New Britain General Hospital)*
Vice President, Operations

The Hospital of Central Connecticut was created with the 2006 merger of the former New Britain General and Bradley Memorial hospitals. Through the University of Connecticut School of Medicine, the hospital participates in residency programs for primary care internal medicine, obstetrics and gynecology, otolaryngology, and general surgery. The hospital is a 414-bed acute care general hospital with two campuses. In my vice president role, I oversee operations to ensure successful execution of the strategic plan, organizational goals and balanced score card priorities.

Selected Accomplishments:

- Merged bariatric services between The Hospital of Central Connecticut and Midstate Medical Center to create a regional program.
- Led the transition of a for-profit rehab entity into a hospital service which enhanced quality, productivity and financial performance.
- Served as executive leader for the Hartford Healthcare Periop Productivity and Efficiency Committee that implemented $900,500 in system savings and $603,436 at the Hospital of Central Connecticut.
- Led the planning, development and implementation of a new Family Health Center where primary care, laboratory, imaging, urgent care and wound care services are provided.
- Planned and implemented wound care services in the New Britain community.
- Implemented an orthopedic hospitalist program.

Director, Cardiovascular, Neurodiagnostic, Interventional Radiology and Outpatient Services

Responsible for leading, planning, organizing and directing operations and services for Noninvasive Cardiology, Interventional Cardiology, Interventional Radiology, Neurodiagnostic Services, Sleep Disorders, Faculty Practice Clinics, Preadmission Testing, Medical, OB/GYN, Pediatric, Surgical, Orthopedic, GI, Podiatry and medical surgical subspecialty clinics. Lead multidisciplinary groups to ensure that quality care is provided and financial integrity is maintained. Planned and implemented an operating budget of $15.2 million with $38 million in billable services.

Selected Accomplishments:

- Achieved a 22% increase in net revenue through reorganization of hospital based faculty practice clinics
- Achieved savings of $117,000 through implementation of an inventory management program in the cardiac cath laboratory and interventional radiology.
- Implemented a Cardiac PET program
- Obtained CON for satellite sleep disorders center
- Achieved ICAEL accreditation status for Echocardiography
- Responsible for the consolidation of select clinical services as part of a two hospital merger.
- Established ENT, Hand, Neurology and Nephrology Clinics
- Leader for hospital wide strategic initiative in redesigning the role of the clinical manager.
- Key participant in the development and implementation of an organizational service excellence program.

NEW BRITAIN GENERAL HOSPITAL, NEW BRITAIN CT

Director, Cardiac, Neuro and Outpatient Services

Responsible for leading, planning, directing, service delivery, operations and financial performance for Cardiology, Neurodiagnostics, Sleep Disorders, Outpatient Clinics, PAT and an Outpatient Diagnostic Laboratory.

- Redesigned clinic billing policies, procedures, and processes which resulted in enhanced revenue capture and reduced compliance risk.
- Achieved a 7.9% increase in activity with zero variance in FTEs and reduced non-salary budget by 28% within the first year of assuming responsibility for the outpatient clinics.
- Implemented strategies that moved patient satisfaction scores from the 4th percentile to the 70th percentile within 8 months of assuming responsibility for an outpatient diagnostic facility.
- Oversaw major facility redesign for a sleep disorders center, outpatient clinics and the

Department of Cardiology

- Connecticut Immunization Registry Best Practice Award recipient for pediatric outpatient service.
- Expansion of a 4-Bed Sleep Disorders Center to a 6-Bed Center with an annual increase in volumes of 44% and a 50% increase in the departmental gross margin.
- Project leader for successful AASM accreditation of a Sleep Disorders Center
- As a member of the IT Steering Committee and Implementation Team, assisted in the assessment, development and implementation of a hospital wide electronic health record

Manager, Department of Cardiology

Responsible for the operations, resource management and patient care for the Department of Cardiology and Cardiac Electrophysiology.

- Developed, implemented and expanded diagnostic service line to include transesophageal echocardiography and outpatient ambulatory cardiac monitoring electrophysiology.
- Development and implementation of a cardiac electrophysiology program.
- Established a cardiology diagnostic satellite.
- Increased gross margin by 30%, 13.3%, 12.4% and 16% for consecutive years.
- Participated in development of organizational work redesign.
- Development of a nurse-managed Coumadin Clinic.
- Developed department performance improvement program
- Developed and marketed a cardiovascular health-screening program for businesses in central Connecticut.

Assistant Nurse Manager, Cardiac Telemetry Unit
RN, Staff/Charge Nurse, Coronary Care Unit
RN, Staff/Charge Nurse, Surgical Unit

MERIDEN WALLINGFORD HOSPITAL, MERIDEN, CT
Staff Nurse, Telemetry Step Down Unit

GAYLORD HOSPITAL, WALLINGFORD, CT
Staff Nurse, Pulmonary Rehabilitation

ACADEMIC POSITIONS

STONE ACADEMY EAST HARTFORD CT
Anatomy and Physiology, Classroom Instructor

UNIVERSITY OF CONNECTICUT SCHOOL OF ALLIED HEALTH
Guest Lecturer, Spring Semester, 1999 and 2000

EDUCATION

AMERICAN MANAGEMENT ASSOCIATION
Leadership Certification Program
2010

MORESTREAM.COM UNIVERSITY
Lean Six Sigma, Certificate of Completion
2010

UNIVERSITY OF HARTFORD
MSN, Management, 1997
3.9 GPA
ConnectiCare Managed Care Company, Administrative Internship, 1/97 – 5/97
University of Connecticut Health Center, Clinical Internship, Cardiac Surgical Program, 1/96 – 5/96
Kappa Delta Pi, Phi Chapter, National Education Society

UNIVERSITY OF HARTFORD
B.S., Health Science, Concentration in Advanced Science and Medicine, 1989
Suma Cum Laude

MATTATUCK COMMUNITY COLLEGE, WATERBURY, CT
A.S., Nursing, 3.9/4.0 GPA, 1982

VINAL VOCATIONAL SCHOOL, MIDDLETOWN, CT
Practical Nurse Certificate, 1978
Honored for highest achievement in academic and clinical areas.

PROFESSIONAL MEMBERSHIPS AND AWARDS

American College of Healthcare Executives
Corporator, The Hospital of Central Connecticut
Board Member, Central Connecticut Chambers of Commerce
Board Member, New Britain Chambers of Commerce

Carolyn M. Freiheit
92 General Patton Drive
Naugatuck, CT 06770
203 415-7161

Summary & Overview

Versatile, highly accomplished, results driven leader who leads through change. Hands on leader with extensive background in healthcare finance and establishing cross functional partnerships to deliver results. Strong qualifications in developing and implementing financial controls and processes in addition to productivity improvements, and change management. Possesses solid leadership, communication and interpersonal skills to establish rapport with all levels of staff and management.

Professional Experience

2013-Present Hartford Healthcare, Inc.
Regional Vice President, Finance **(2 acute care hospitals $500M Revenue)**
2003- 2013 The Hospital of Central Connecticut, New Britain, CT
Director of Finance 2006 – Present
Director of Budget 2003- 2006

- Reimbursement: Responsible for cost report analysis, reimbursement initiatives, modeling federal payments rules, and assessing reserve/settlement projections and net accounts receivable analysis.
- Budget: Launch new system, provide training to supervisory, middle management and executive level organization, manage operating and capital budget, prepare board presentations, and coordinate timely and effective distribution of data.
- Decision Support: Maintain integrity of data; provide ROI analysis, and productivity monitoring software. Interpretation and evaluate of productivity monitoring data, forecasting.
- General Accounting: Manage annual financial statement, federal grant and pension audits; OHCA filing reviews. Manage payment processing, maintain compliance procedures for endowment investments and properly account for restricted funds.
- Accounts Payable: Identify and implement technological solutions to replace manual processes within accounts payable, direct payment processing thru proper cash flow management.
- Human resources: Hiring, performance appraisals, compensation, staff development, role modeling and coaching/mentoring.
- Additional Projects: Chargemaster Maintenance, integration of fixed assets with accounts payable system, institute bar coding for fixed assets
- Strategize with investment managers, consultants, auditors, and fund trustees.
- Redesign department for improve productivity, efficiency and service to internal and external customers.
- Participate and plan board committee meetings including presentation materials and coordination of external consultants or auditors.

1997-2003 Waterbury Hospital, Waterbury CT
Assistant Director of Finance 1999 – 2003
Reimbursement Analyst 1997- 1999

1994-1997 Milford Hospital, Milford CT
Reimbursement Analyst
1990-1994 Griffin Hospital, Derby CT
Senior Accountant

Professional Organizations & Community Leadership

CenConn Services	2013 - present
Hospital of Central Connecticut	2013 - present
Midstate Medical Center	2013 - present
Meriden Imaging Center	2013 - present
Corperator of Hospital of Central Connecticut	2009 - present
HealthCare Financial Management	2003 - present
Naugatuck Congregational Church	Finance Committee & Stewardship Committee

Education

Sacred Heart University and University of Connecticut MBA
Western CT State University Bachelors of Science; Major in Accounting
Bay Path College Associates of Science; Major in Accounting

Exhibit 9

Hartford Healthcare
Financial Assistance Policy

Update Date: 12/16/2010

Purpose: The purpose of this Policy is to set forth the policy of Hartford Healthcare Corporation (sometimes referred to as the "System") governing the provision of free or discounted Health Care Services to patients who meet the System's criteria for Financial Assistance. Specifically, this Policy will describe: (i) the eligibility criteria for Financial Assistance, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for Financial Assistance from the System's Hospitals; (iv) the actions the System may take in the event of non-payment, including collections action and reporting to credit agencies for patients that qualify for Financial Assistance; and (v) the System measures to widely publicize this Policy within the community served by Hartford Healthcare.

Scope: This Policy applies to all Hartford Health facilities Health Care Services regardless of the location at which they are being provided by the System.

Definitions:

"Charges" means for a Health Care Service for a patient who is either Uninsured or Underinsured and who is eligible for Financial Assistance, the average of the System's facility three best negotiated commercial payor rates for the Health Care Services.

"Eligibility Criteria" means the criteria set forth in this Policy to determine whether a patient qualifies for Financial Assistance for the Health Care Services provided by the System's facility.

"EMTALA" means the Emergency Medical Treatment and Labor Act, 42 USC 1395dd, as amended from time to time.

"Family" means pursuant to the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union or adoption. For purposes of this Policy, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

"Family Income" means the following income when calculating Federal Poverty Level Guidelines of liquid assets: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources of

income. If a person lives with a Family, Family Income includes the income of all Family members.

"Federal Poverty Level Guidelines" means the federal poverty level guidelines established by the United States Department of Health and Human Services.

"Financial Assistance" means free or discounted Health Care Services provided to persons who, pursuant to the Eligibility Criteria, the Hospital has determined to be unable to pay for all or a portion of the Health Care Services.

"Free Bed Funds" means any gift of money, stock, bonds, financial instruments or other property made by any donor to Hartford Healthcare facilities for the purpose of establishing a fund to provide medical care to an inpatient or outpatient of Hartford Healthcare.

"Health Care Services" means Hartford Healthcare facilities (i) emergency medical services as defined by EMTALA; (ii) services for a condition which, if not promptly treated, will result in adverse change in the health status of the individual; (iii) non-elective services provided in response to life-threatening circumstances in a non-emergency department setting; and (iv) medically necessary services as determined by the System facility on a case-by-case basis at the facility's discretion.

"Medically Indigent" means persons whom the System facility has determined to be unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their Family Income or Family assets even though they have income or assets that otherwise exceed the generally applicable Eligibility Criteria for free or discounted care under the Policy.

"Uninsured" means a patient who has no level of insurance or third party assistance to assist in meeting his or her payment obligations for Health Care Services and is not covered by Medicare, Medicaid or Champus or any other health insurance program of any nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

"Underinsured" means the patient has some level of insurance or third-party assistance but still has out-of-pocket expenses such as high deductible plans that exceed his or her level of financial resources.

Policy: It is Hartford Healthcare's policy to provide Financial Assistance to all eligible individuals who are Uninsured, Underinsured, ineligible for a government program, or otherwise unable to pay for Health Care Services due to their limited financial resources. It is also the System's policy to provide without discrimination care for emergency medical conditions (as defined by EMTALA) to individuals regardless of their eligibility for Financial Assistance under this Policy or for government assistance.

I. Determining Eligibility.

In determining eligibility for Financial Assistance, it is important that both the System facility and the patient work collaboratively. Specifically, the System facilities will do its best to apply the Eligibility Criteria in a flexible and reasonable manner and the patient will do its best in responding to Hartford Healthcare requests for information in a timely manner.

1. Eligibility for Financial Assistance. Individuals who are Uninsured, Underinsured, ineligible for any government health care benefit program and unable to pay for their Health Care Services may be eligible for Financial Assistance pursuant to this Policy. The granting of Financial Assistance shall be based upon an individualized determination of financial need, and shall not take into account age, gender, race, color, national origin, marital status, social or immigrant status, sexual orientation or religious affiliation.

2. Process for Determining Eligibility for Financial Assistance. In connection with determining eligibility for Financial Assistance, the System (i) will require that the patient complete an application for Financial Assistance along with providing other financial information and documentation relevant to making a determination of financial eligibility; (ii) may rely upon publicly available information and resources to determine the financial resources of the patient or a potential guarantor; (iii) may pursue alternative sources of payment from public and private payment benefit programs; (iv) may review the patient's prior payment history; and (v) may consider the patient's receipt of state-funded prescription programs, participation in Women, Infants and Children programs, food stamps, subsidized school lunches, subsidized housing, or other public assistance as presumptive eligibility when there is insufficient information provided by the patient to determine eligibility.

3. Processing Requests. Hartford Healthcare will use its best efforts to facilitate the determination process prior to rendering services so long as the determination process does not interfere with the provision of emergency medical services as defined under federal law. However, eligibility determinations can be made at any time during the revenue cycle. During the eligibility determination process, the System facilities will at all times treat the patient or their authorized representative with dignity and respect and in accordance with all state and federal laws.

4. Financial Assistance Guidelines. Eligibility criteria for Financial Assistance may include, but is not limited to, such factors as Family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. Family size is determined based upon the number of dependents living in the household. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

(a) ***Uninsured Patients:***

(i) If Family income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the System facility's Charges for Health Care Services;

(ii) If Family income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 50% discount against the System facility's Charges for Health Care Services;

(iii) Patients may also qualify for Free Bed Funds in accordance with the Hartford Healthcare Free Bed Funds Policy; and

(iv) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(b) ***Underinsured Patients:***

(i) Payment plans will be extended for any patient liability (including without limitation to amounts due under high deductible plans) identified in a manner consistent with the System's Payment Plan Policy;

(ii) If Family Income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the Charges for the Health Care Services;

(iii) If Family Income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to 50% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the Charges for the Health Care Services;

(v) Patients may also qualify for Free Bed Funds in accordance with Hartford Healthcare Free Bed Funds Policy; and

(vi) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(c) ***Medically Indigent:*** Patients will be required to submit a Financial Assistance application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that the Hartford Healthcare System Hardship Committee can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities.

II. Method for Applying for Financial Assistance. Patients may ask any nurse, physician, chaplain, or staff member from Patient Registration, Patient Accounts, Office of Professional Services, Case Coordination, or Social Services about initiating the Financial Assistance application process. Information about applying for Financial Assistance is also available online at www.hartfordhealthcare.org. Signage and written information regarding how to apply for Financial Assistance will be available in Hartford Healthcare facilitiesl emergency service and patient registration areas. Once a patient or his or her legal representative requests information about Financial Assistance, a Financial Counselor will provide the patient or his or her legal representative with the Financial Assistance application along with a list of the required documents that must be provided to process the application. If the patient or his or her legal representative does not provide the necessary documentation and information required to make a Financial Eligibility determination within fourteen (14) calendar days of the Hartford Healthcare facility's request, the Financial Assistance application will be deemed incomplete and rendered void. However, if an application is deemed complete by the System facility, the System facility will provide to the patient or his or her legal representative a written determination of financial eligibility within five (5) business days. Decisions by the System facilities that the patient does not qualify for Financial Assistance may be appealed by the patient or his or her legal representative within fourteen (14) calendar days of the determination. If the patient or his or her legal representative appeals the determination, the Director of Patient Access will review the determination along with any new information and render a final decision within five (5) business days.

III. Relationship to Hartford Healthcare Collection Practices. In the event a patient fails to qualify for Financial Assistance or fails to pay their portion of discounted Charges pursuant to this Policy, and the patient does not pay timely their obligations to Hartford Healthcare, the System reserves the right to institute and pursue collection actions and to pursue any remedies available at law or in equity, including but not limited to, imposing wage garnishments or filing and foreclosing on liens on primary residences or other assets, instituting and prosecuting legal actions and reporting the matter to one or more credit rating agencies. For those patients who qualify for Financial Assistance and who, in the System's sole determination, are cooperating in good faith to resolve the System's outstanding accounts, the System facilities may offer extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, will not send unpaid bills to outside collection agencies and will cease all collection efforts.

IV. Publication and Education. Hartford Healthcare facilities will disseminate information about its Financial Assistance Policy as follows: (i) provide signage

regarding this Policy and written summary information describing the Policy along with financial assistance contact information in the Emergency Department, Labor and Delivery areas and all other System patient registration areas; (ii) directly provide to each patient written summary information describing the Policy along with financial assistance contact information in all admission, patient registration, discharge, billing and collection written communications; (iii) post the Policy on the System's web site with clear linkage to the Policy on the System's home page; (iv) educate all admission and registration personnel regarding the Policy so that they can serve as an informational resource to patients regarding the Policy; and (v) include the tag line "Please ask about our Financial Assistance Policy" in all Hartford Healthcare written advertisements.

V. Relation to Free Bed Funds. If a patient applies for Financial Assistance, Hartford Healthcare facilities will determine his or her eligibility for Financial Assistance and or Free Bed Funds.

VI. Regulatory Compliance. The System will comply with all state and federal laws, rules and regulations applicable to the conduct described in this Policy.

Reviewed By:	Niobus Queiro, Revenue Cycle Director, Hartford Healthcare Corporation
	Shelly McCafferty, PFS Director, Hartford Healthcare Corporation
	Becky Peters, PAS Director, Hartford Hospital
	Joan Feldman, Legal Counsel to Hartford Healthcare Corporation
Approved By:	_____ **Thomas Marchozzi, EVP & CFO Hartford Healthcare Corp.**
Date:	_____**October 1, 2010**_____

Issued Date: 08/16/2010

Exhibit 10

NON-PROFIT

Applicant:

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Financial Worksheet (A)

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
	Total Entity:	FY 2014	FY 2016	FY 2016		FY 2017	FY 2017		FY 2018	FY 2018		FY 2019	FY 2019	
LINE		Actual	Projected	Projected		Projected	Projected		Projected	Projected		Projected	Projected	
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	A. OPERATING REVENUE													
1	Total Gross Patient Revenue	864,609,377	838,089,000	($848,190)	$837,240,810	$813,777,000	($865,154)	$812,911,846	$806,441,000	($891,109)	$805,549,891	$804,788,000	($908,931)	$803,879,069
2	Less: Allowances	480,182,282	$494,373,000	($635,521)	$493,737,479	$463,574,818	($652,485)	$462,922,333	$455,018,235	($678,440)	$454,339,795	$449,691,006	($696,262)	$448,994,744
3	Less: Charity Care	17,256,889	$11,390,000		$11,390,000	$11,299,306		$11,299,306	$11,235,310		$11,235,310	$11,226,453		$11,226,453
4	Less: Other Deductions	0		$0	$0		$0	$0		$0	$0		$0	$0
	Net Patient Service Revenue	367,170,206	$332,326,000	($212,669)	$332,113,331	$338,902,876	($212,669)	$338,690,207	$340,187,455	($212,669)	$339,974,786	$343,870,541	($212,669)	$343,657,872
5	Medicare	138,054,052	$124,952,815		$124,952,815	$127,425,686		$127,425,686	$127,908,681		$127,908,681	$129,293,501		$129,293,501
6	Medicaid	59,639,703	$53,979,935	($212,669)	$53,767,266	$55,048,222	($212,669)	$54,835,553	$55,296,877	($212,669)	$55,044,208	$55,855,123	($212,669)	$55,642,454
7	CHAMPUS & TriCare	282,264	$255,477		$255,477	$260,533		$260,533	$261,521		$261,521	$264,352		$264,352
8	Other			$0	$0		$0	$0		$0	$0		$0	$0
	Total Government	197,976,019	$179,188,228	($212,669)	$178,975,559	$182,734,441	($212,669)	$182,521,772	$183,427,078	($212,669)	$183,214,409	$185,412,976	($212,669)	$185,200,307
9	Commercial Insurers	150,846,650	$136,531,585		$136,531,585	$139,233,605		$139,233,605	139,761,356		$139,761,356	141,274,502		$141,274,502
10	Uninsured			$0	$0		$0	$0		$0	$0		$0	$0
11	Self Pay	8,818,166	$7,981,328		$7,981,328	$8,139,281.92		$8,139,282	8,170,133		$8,170,133	8,258,588		$8,258,588
12	Workers Compensation	5,499,389	$4,977,501		$4,977,501	$5,076,007.58		$5,076,008	5,095,248		$5,095,248	5,150,412		$5,150,412
13	Other	4,029,782	$3,647,358		$3,647,358	$3,719,541.20		$3,719,541			$0			$0
	Total Non-Government	169,194,187	$153,137,772	$0	$153,137,772	$156,168,435	$0	$156,168,435	$153,026,737	$0	$153,026,737	$154,683,502	$0	$154,683,502
	Net Patient Service Revenue[a] (Government+Non-Government)	367,170,206	$332,326,000	($212,669)	$332,113,331	$338,902,876	($212,669)	$338,690,207	$340,187,455	($212,669)	$339,974,786	$343,870,541	($212,669)	$343,657,872
14	Less: Provision for Bad Debts	5,458,239	$6,175,000		$6,175,000	$6,126,847		$6,126,847	$6,092,146		$6,092,146	$6,087,343		$6,087,343
	Net Patient Service Revenue less provision for bad debts	361,711,967	$326,151,000	($212,669)	$325,938,331	$332,776,029	($212,669)	$332,563,360	$334,095,309	($212,669)	$333,882,640	$337,783,198	($212,669)	$337,570,529
15	Other Operating Revenue	11,024,317	$15,152,000		$15,152,000	$15,912,000		$15,912,000	$16,289,000		$16,289,000	$16,676,000		$16,676,000
17	Net Assets Released from Restrictions	1,351,596	$1,400,000		$1,400,000	$1,416,000		$1,416,000	$1,465,000		$1,465,000	$1,517,000		$1,517,000
	TOTAL OPERATING REVENUE	374,087,880	$342,703,000	($212,669)	$342,490,331	$350,104,029	($212,669)	$349,891,360	$351,849,309	($212,669)	$351,636,640	$355,976,198	($212,669)	$355,763,529
	B. OPERATING EXPENSES													
1	Salaries and Wages	148,416,218	$138,379,000	($881,601)	$137,497,399	$141,541,000	($903,641)	$140,637,359	$145,221,000	($930,750)	$144,290,250	$150,014,000	($949,365)	$149,064,635
2	Fringe Benefits	45,122,344	$41,719,000	($202,000)	$41,517,000	$42,387,000	($203,000)	$42,184,000	$43,526,000	($203,500)	$43,322,500	$44,986,000	($204,000)	$44,782,000
3	Physicians Fees	9,980,614	$10,190,000		$10,190,000	$10,000,000		$10,000,000	$10,025,000		$10,025,000	$10,056,000		$10,056,000
4	Supplies and Drugs	49,864,651	$35,915,000		$35,915,000	$39,331,000		$39,331,000	$39,689,000		$39,689,000	$41,526,000		$41,526,000
5	Depreciation and Amortization	18,225,335	$19,460,000		$19,460,000	$14,085,000		$14,085,000	$12,103,000		$12,103,000	$10,641,000		$10,641,000
6	Provision for Bad Debts-Other[b]	0	$0		$0			$0			$0			$0
7	Interest Expense	1,418,199	$3,268,000		$3,268,000	$3,221,000		$3,221,000	$3,219,000		$3,219,000	$3,087,000		$3,087,000
8	Malpractice Insurance Cost	3,957,824	$3,635,000		$3,635,000	$3,748,000		$3,748,000	$3,860,000		$3,860,000	$3,168,000		$3,168,000
9	Lease Expense		$0		$0			$0			$0			$0
10	Other Operating Expenses	82,318,899	$81,400,000		$81,400,000	$83,005,000		$83,005,000	$80,487,000		$80,487,000	$78,616,000		$78,616,000
	TOTAL OPERATING EXPENSES	359,304,084	$333,956,000	($1,083,601)	$332,872,399	$337,318,000	($1,106,641)	$336,211,359	$338,110,000	($1,134,250)	$336,975,750	$342,094,000	($1,153,365)	$340,940,635
	INCOME/(LOSS) FROM OPERATIONS	14,783,796	$8,747,000	$870,932	$9,617,932	$12,786,029	$893,972	$13,680,001	$13,739,309	$921,582	$14,660,891	$13,882,198	$940,696	$14,822,894
	NON-OPERATING REVENUE	9,562,104	$2,000,000		$2,000,000	$5,000,000		$5,000,000	$5,000,000		$5,000,000	$5,000,000		$5,000,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	24,345,900	$10,747,000	$870,932	$11,617,932	$17,786,029	$893,972	$18,680,001	$18,739,309	$921,582	$19,660,891	$18,882,198	$940,696	$19,822,894
	Principal Payments	2,329,000	$2,100,000		$2,100,000	$1,950,000		$1,950,000	$1,800,000		$1,800,000	$1,700,000		$1,700,000
	C. PROFITABILITY SUMMARY													
1	Hospital Operating Margin	3.85%	2.5%	-409.5%	2.8%	3.6%	-420.4%	3.9%	3.9%	-433.3%	4.1%	3.8%	-442.3%	4.1%
2	Hospital Non Operating Margin	2.49%	0.6%	0.0%	0.6%	1.4%	0.0%	1.4%	1.4%	0.0%	1.4%	1.4%	0.0%	1.4%
3	Hospital Total Margin	6.35%	3.1%	-409.5%	3.4%	5.0%	-420.4%	5.3%	5.3%	-433.3%	5.5%	5.2%	-442.3%	5.5%
	D. FTEs	1,894	1,788	(7)	1,782	1,788	(7)	1,782	1,788	(7)	1,781	1,788	(7)	1,781
	E. VOLUME STATISTICS[c]													
1	Inpatient Discharges	15,640	14,750	(3,500)	14,750	14,750	(3,500)	14,750	14,750	(3,500)	14,750	14,750	(3,500)	14,750
2	Outpatient Visits	403,498	411,568		408,068	415,684		412,184	417,762		414,262	418,806		415,306
	TOTAL VOLUME	419,138	426,318	(3,500)	422,818	430,434	(3,500)	426,934	432,512	(3,500)	429,012	433,556	(3,500)	430,056

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Huber, Jack
Sent: Friday, September 18, 2015 3:25 PM
To: Durdy, Barbara (Barbara.Durdy@hhchealth.org)
Cc: Roberts, Karen; Foster, Tillman; Greer, Leslie; Huber, Jack
Subject: Completeness Letter - DN: 15-32023-CON

Dear Ms. Durdy:

On August 28, 2015, OHCA received the Certificate of Need application of The Hospital of Central Connecticut proposing to terminate inpatient and outpatient pediatric services at HOCC in New Britain. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 123** and reference "**Docket Number: 15-32023-CON**."

1. Clarify if CCMC is the only hospital that HOCC has an Emergency Patient Transfer Agreement with related to pediatric patients? If not, identify other providers HOCC has agreements with.
2. Clarify whether CMMC's Waterbury inpatient unit will receive HOCC referrals or transfers or just the CCMC Hartford location?
3. Will pediatric emergencies continue to be brought to the HOCC ED by air/ground ambulance or will they be transported directly to CCMC or other tertiary hospitals?
4. How many pediatric patients were transferred from HOCC to CCMC during FY 2014 and FY 2015?
5. Will transferred patients receive two ED charges (one from HOCC and one from CCMC) as well as two ambulance charges (to HOCC and then to CCMC)?
6. If a pediatric patient presents at the HOCC ED and requires emergency surgery, will the patient be transported to CCMC before emergency surgery or after?
7. Will the proposal impact the continuation or volume of pediatric surgery at HOCC? If so, please describe the impact in quantifiable terms.
8. Provide Table 7 Payer Mix specific to the inpatient pediatric services.
9. Resubmit Table 8 (both the inpatient and outpatient tables) using only incorporated Connecticut town names.
10. Does HOCC continue to take new patients into the pediatric clinic at this time?
11. Submit the missing draft "bilingual (English/Spanish) patient communication" which is referred to in the Pediatric Clinic Transition of Care Plan.
12. Provide a comparison of HOCC's Pediatric Clinic charges to Community Health Center's clinic charges.
13. Does the Pediatric Clinic serve only Medicaid patients as seems to be indicated from the financial projections on page 122?
14. The Exhibit 5 letters of support from area pediatricians acknowledge that they are interested in and have the capacity to accept new pediatric patients. Does this interest and capacity specifically extend to Medicaid patients?
15. Have the salary/benefit expenses for the agreed to CHC position (pediatrician or pediatric nurse practitioner) been accounted for in the financial projections, and if so, please specify how accounted for.

16. Per page 30, 182 clinic patients in FY 2014 were from Bristol. The Community Health Center of Bristol is not in the listings provided in Table 9 or Table A (page 36). Please explain the omission.
17. HOCC did not provide hours/days of operation for most of the private practices in Table 9. Please resubmit this list with the hours/days of operation information.
18. The FY 2016 Gain/Loss from operations (Table 4, page 26) is incorrect. Please revise.
19. Does the reduction in revenues, expenses and volume in Exhibit 10 only reflect the closing of the pediatric clinic or is a reduction in pediatric ED visits or pediatric surgery also reflected in these numbers?
20. HOCC lists FY 2014 pediatric discharges as **135** on Table 5. Per FY 2014 HRS Report 400, inpatient pediatric discharges were identified as **206**. Please reconcile these two amounts and also compare to the FY 2014 discharges provided in the Inpatient Discharge Database for pediatric patients age 6 months to 17 years (see table below).

HOSPITAL OF CENTRAL CONNECTICUT INPATIENT DISCHARGES
AGES 6 MONTHS to 17 YEARS OLD: FYs 2011 -2014

	DISCHARGES				PATIENT DAYS			
SERVICE LINE	FY 2011	FY 2012	FY 2013	**FY 2014**	FY 2011	FY 2012	FY 2013	FY 2014
Newborn				**1**				7
Maternity	47	44	50	**20**	130	112	149	47
Psychiatric	1	2	1	**1**	4	6	2	1
Pediatric	227	159	232	**144**	432	326	414	267
Medical/Surgical	67	61	57	**24**	146	114	110	52
Total	342	266	340	**190**	712	558	675	374

Source: *CT Department of Public Health Acute Care Hospital Inpatient Discharge Database*

21. Will HOCC still have Maternity, Psychiatric or Surgical discharges for this age co-hort?

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than Monday, November 16, 2015, otherwise your application will be automatically considered withdrawn. ***Please email your responses to all of the following email addresses:*** OHCA@ct.gov, ***karen.roberts@ct.gov, jack.huber@ct.gov, tillman.foster@ct.gov.*** If you have any questions concerning this letter, please feel free to contact me at (860) 418-7069, Karen Roberts at (860) 418-7041 or Tillman Foster at (860) 418-7031.

Sincerely,

Jack A. Huber
Health Care Analyst

Greer, Leslie

From: Durdy, Barbara <Barbara.Durdy@hhchealth.org>
Sent: Friday, September 18, 2015 3:48 PM
To: Huber, Jack
Cc: Roberts, Karen; Foster, Tillman; Greer, Leslie
Subject: RE: Completeness Letter - DN: 15-32023-CON

Jack,
Good afternoon.
I will send in our responses as soon as possible.
Enjoy the weekend,
Barbara

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Sent: Friday, September 18, 2015 3:25 PM
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Cc: Roberts, Karen; Foster, Tillman; Greer, Leslie; Huber, Jack
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Sincerely,

Jack A. Huber
Health Care Analyst

Greer, Leslie

From: Roberts, Karen
Sent: Wednesday, October 14, 2015 4:19 PM
To: Greer, Leslie
Subject: FW: Completeness Letter - DN: 15-32023-CON
Attachments: 14 - HOCC Pedi Clinic Charges.xlsx; 15 - Copy of financial_workbook_-_october 2015.xlsx; Completeness - Docket No. 15-32023-CON.pdf; Completeness Response HOCC Termination of Inpatient and Outpatient Pediatric Services.docx

Leslie – for the original and PDF files. Karen

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Wednesday, October 14, 2015 4:04 PM
To: Huber, Jack; Foster, Tillman; Roberts, Karen; User, OHCA
Cc: Mack, David (David.Mack@hhchealth.org); Durdy, Barbara (Barbara.Durdy@hhchealth.org)
Subject: FW: Completeness Letter - DN: 15-32023-CON

Dear Jack:
Attached on behalf of HOCC, I attach its responses to your completeness questions in your e mail of September 18, 2015. All of the tables can be found in the PDF document.
Thank you and if you have questions, please do not hesitate to call me.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

From: Huber, Jack [mailto:Jack.Huber@ct.gov]
Sent: Friday, September 18, 2015 3:25 PM
To: Durdy, Barbara
Cc: Roberts, Karen; Foster, Tillman; Greer, Leslie; Huber, Jack
Subject: Completeness Letter - DN: 15-32023-CON

Dear Ms. Durdy:

On August 28, 2015, OHCA received the Certificate of Need application of The Hospital of Central Connecticut proposing to terminate inpatient and outpatient pediatric services at HOCC in New Britain. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's

document preceding it. Please begin your submission using **Page 123** and reference "**Docket Number: 15-32023-CON**."

1. Clarify if CCMC is the only hospital that HOCC has an Emergency Patient Transfer Agreement with related to pediatric patients? If not, identify other providers HOCC has agreements with.
2. Clarify whether CMMC's Waterbury inpatient unit will receive HOCC referrals or transfers or just the CCMC Hartford location?
3. Will pediatric emergencies continue to be brought to the HOCC ED by air/ground ambulance or will they be transported directly to CCMC or other tertiary hospitals?
4. How many pediatric patients were transferred from HOCC to CCMC during FY 2014 and FY 2015?
5. Will transferred patients receive two ED charges (one from HOCC and one from CCMC) as well as two ambulance charges (to HOCC and then to CCMC)?
6. If a pediatric patient presents at the HOCC ED and requires emergency surgery, will the patient be transported to CCMC before emergency surgery or after?
7. Will the proposal impact the continuation or volume of pediatric surgery at HOCC? If so, please describe the impact in quantifiable terms.
8. Provide Table 7 Payer Mix specific to the inpatient pediatric services.
9. Resubmit Table 8 (both the inpatient and outpatient tables) using only incorporated Connecticut town names.
10. Does HOCC continue to take new patients into the pediatric clinic at this time?
11. Submit the missing draft "bilingual (English/Spanish) patient communication" which is referred to in the Pediatric Clinic Transition of Care Plan.
12. Provide a comparison of HOCC's Pediatric Clinic charges to Community Health Center's clinic charges.
13. Does the Pediatric Clinic serve only Medicaid patients as seems to be indicated from the financial projections on page 122?
14. The Exhibit 5 letters of support from area pediatricians acknowledge that they are interested in and have the capacity to accept new pediatric patients. Does this interest and capacity specifically extend to Medicaid patients?
15. Have the salary/benefit expenses for the agreed to CHC position (pediatrician or pediatric nurse practitioner) been accounted for in the financial projections, and if so, please specify how accounted for.
16. Per page 30, 182 clinic patients in FY 2014 were from Bristol. The Community Health Center of Bristol is not in the listings provided in Table 9 or Table A (page 36). Please explain the omission.
17. HOCC did not provide hours/days of operation for most of the private practices in Table 9. Please resubmit this list with the hours/days of operation information.
18. The FY 2016 Gain/Loss from operations (Table 4, page 26) is incorrect. Please revise.
19. Does the reduction in revenues, expenses and volume in Exhibit 10 only reflect the closing of the pediatric clinic or is a reduction in pediatric ED visits or pediatric surgery also reflected in these numbers?
20. HOCC lists FY 2014 pediatric discharges as **135** on Table 5. Per FY 2014 HRS Report 400, inpatient pediatric discharges were identified as **206**. Please reconcile these two amounts and also compare to the FY 2014 discharges provided in the Inpatient Discharge Database for pediatric patients age 6 months to 17 years (see table below).

HOSPITAL OF CENTRAL CONNECTICUT INPATIENT DISCHARGES
AGES 6 MONTHS to 17 YEARS OLD: FYs 2011 -2014

	DISCHARGES				PATIENT DAYS			
SERVICE LINE	FY 2011	FY 2012	FY 2013	**FY 2014**	FY 2011	FY 2012	FY 2013	FY 2014
Newborn				**1**				7
Maternity	47	44	50	**20**	130	112	149	47
Psychiatric	1	2	1	**1**	4	6	2	1

Pediatric	227	159	232	**144**	432	326	414	267
Medical/Surgical	67	61	57	**24**	146	114	110	52
Total	342	266	340	**190**	712	558	675	374

Source: *CT Department of Public Health Acute Care Hospital Inpatient Discharge Database*

21. Will HOCC still have Maternity, Psychiatric or Surgical discharges for this age co-hort?

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than Monday, November 16, 2015, otherwise your application will be automatically considered withdrawn. ***Please email your responses to all of the following email addresses:*** OHCA@ct.gov, ***karen.roberts@ct.gov, jack.huber@ct.gov, tillman.foster@ct.gov.*** If you have any questions concerning this letter, please feel free to contact me at (860) 418-7069, Karen Roberts at (860) 418-7041 or Tillman Foster at (860) 418-7031.

Sincerely,

Jack A. Huber
Health Care Analyst

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

October 14, 2015

VIA EMAIL

Jack A. Huber
Health Care Analyst
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
PO Box 340308
Hartford, CT 06134

RE: Hospital of Central Connecticut Termination of Inpatient and Outpatient Pediatric Services at New Britain
Completeness Letter Responses: Docket Number: 15-32023-CON

Dear Mr. Huber:

On behalf of Hospital of Central Connecticut at New Britain, attached please find the Applicants' responses to your Certificate of Need Completeness Email dated September 18, 2015. As requested, I have emailed a copy of the Applicant's entire response (including attachments or exhibits), and electronic versions of any Microsoft Word or Excel documents, as applicable.

Please do not hesitate to contact me at 860-251-5104 if you have any questions..

Sincerely,

Joan W. Feldman

JWF/tja
Enclosures
7193v10

The Hospital of Central Connecticut
Certificate of Need Application; Docket Number: 15-32023-CON
Termination of Inpatient and Outpatient Pediatric Services
October 14, 2015

Response to Completeness Questions

On August 28, 2015, OHCA received the Certificate of Need application of The Hospital of Central Connecticut proposing to terminate inpatient and outpatient pediatric services at HOCC in New Britain. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 123** and reference "**Docket Number: 15-32023-CON**."

1. Clarify if CCMC is the only hospital that HOCC has an Emergency Patient Transfer Agreement with related to pediatric patients? If not, identify other providers HOCC has agreements with.

   Yes. CCMC is the only hospital that HOCC has a Patient Transfer Agreement with specifically for pediatric patients.

2. Clarify whether CCMC's Waterbury inpatient unit will receive HOCC referrals or transfers or just the CCMC Hartford location?

   CCMC triage controls the admissions to the pediatric unit at Saint Mary's Hospital in Waterbury. Patients will be considered for transfer to the Saint Mary's unit per the triaging CCMC physician accepting care from HOCC.

3. Will pediatric emergencies continue to be brought to the HOCC ED by air/ground ambulance or will they be transported directly to CCMC or other tertiary hospitals?

   HOCC has no control over which emergency department patients are transported to. Emergency Medical Service (EMS) protocols dictate where pediatric emergencies are transported. These protocols will not change if this proposal is approved by OHCA.

4. How many pediatric patients were transferred from HOCC to CCMC during FY 2014 and FY 2015?

   In FY 2014, a total of 199 pediatric patients were transferred from HOCC to CCMC
   185 patients were transferred from the ED
   8 patients were transferred from the NICU
   6 patients were transferred from the inpatient unit

   In FY 2015, a total of 319 pediatric patients were transferred from HOCC to CCMC
   311 patients were transferred from the ED
   8 patients were transferred from the NICU

   In FY 2015, pediatric hospitalists resigned from HOCC and community pediatricians have since directed their patients for admission to CCMC. This resulted in an increase in transfer activity between HOCC and CCMC. When a patient comes to the emergency department and their pediatrician determines that the patient requires admission, the pediatrician directs the transfer / admission to CCMC.

5. Will transferred patients receive two ED charges (one from HOCC and one from CCMC) as well as two ambulance charges (to HOCC and then to CCMC)?

   If a patient is transported by ambulance to the emergency department at HOCC, they will be triaged and stabilized before being transported to CCMC. If the pediatrician determines that the patient requires inpatient care, they will be transported to the emergency room at CCMC or directly admitted to a CCMC inpatient unit. In this scenario, the patient receives two ambulance charges (assuming that they arrive at the HOCC ED by ambulance) and one emergency room charge as care received in the CCMC emergency department will be included in the reimbursement for the inpatient admission by Medicaid.

6. If a pediatric patient presents at the HOCC ED and requires emergency surgery, will the patient be transported to CCMC before emergency surgery or after?

   All pediatric patients are treated and stabilized prior to transfer. If, based upon existing competencies, surgery and post-operative care cannot be provided at HOCC, the patient would be transferred to CCMC prior to surgery.

7. Will the proposal impact the continuation or volume of pediatric surgery at HOCC? If so, please describe the impact in quantifiable terms?

   The proposal will not impact the continuation or current volume of pediatric surgery at HOCC.

8. Provide Table 7 Payer Mix specific to the inpatient pediatric services.

   Please see Exhibit 11 for Table 7 revised to reflect inpatient pediatrics services only.

9. Resubmit Table 8 (both the inpatient and outpatient tables) using only incorporated Connecticut town names.

   Please see Exhibit 12 for revised Table 8 to reflect incorporated Connecticut town names.

10. Does HOCC continue to take new patients into the pediatric clinic at this time?

    Yes. HOCC continues to accept new patients into the pediatric clinic.

11. Submit the missing draft "bilingual (English/Spanish) patient communication" which is referred to in the Pediatric Clinic Transition of Care Plan.

    Please see Exhibit 13 for a copy of the bilingual patient communication. The Spanish translation will be completed pending CON approval.

12. Provide a comparison of HOCC's Pediatric Clinic charges to Community Health Center's clinic charges.

    The community health center charges a flat rate of $154.00 for all medical services, all inclusive regardless of time, complexity, procedures or materials. The Medicaid reimbursement to the community health center is $154.00.

    HOCC's clinic charges are based on an established hospital fee schedule. HOCC's Medicaid reimbursement is $57.23 for a clinic visit. Please see Exhibit 14 for a copy of HOCC clinic charges.

13. Does the Pediatric Clinic serve only Medicaid patients as seems to be indicated from the financial projections on page 122?

    The pediatric clinic at HOCC primarily serves Medicaid patients. However a small percentage (.6%) of patients have commercial insurance and 2% of patients are uninsured. The financial projections on page 122 of the CON application reflect both inpatient and outpatient services.

14. The Exhibit 5 letters of support from area pediatricians acknowledge that they are interested in and have the capacity to accept new pediatric patients. Does this interest and capacity specifically extend to Medicaid patients?

    Yes. Community pediatricians in the greater New Britain area accept Medicaid patients and are willing to accept Medicaid patients from HOCC.

15. Have the salary/benefit expenses for the agreed to CHC position (pediatrician or pediatric nurse practitioner) been accounted for in the financial projections, and if so, please specify how accounted for?

    Please see Exhibit 15 revised to reflect the salary and benefit expense of the CHC position funded by HOCC.

16. Per page 30, 182 clinic patients in FY 2014 were from Bristol. The Community Health Center of Bristol is not in the listings provided in Table 9 or Table A (page 36). Please explain the omission.

    The Community Health Center of Bristol was not included in Table 9 or Table A because Bristol is not considered to be a primary service area town. If patients residing in Bristol would like to be referred to the Community Health Center of Bristol, we will honor their request.

17. HOCC did not provide hours/days of operation for most of the private practices in Table 9. Please resubmit this list with the hours/days of operation information.

    Please see Exhibit 16 for a revised copy of Table 9.

18. The FY 2016 Gain/Loss from operations (Table 4, page 26) is incorrect. Please revise.

    Please see Exhibit 17 for a revised copy of Table 4.

19. Does the reduction in revenues, expenses and volume in Exhibit 10 only reflect the closing of the pediatric clinic or is a reduction in pediatric ED visits or pediatric surgery also reflected in these numbers?

    Reductions in revenues, expenses and volume as depicted in Exhibit 10 are only related to the closure of the pediatric clinic.

20. HOCC lists FY 2014 pediatric discharges as **135** on Table 5. Per FY 2014 HRS Report 400, inpatient pediatric discharges were identified as **206**. Please reconcile these two amounts and also compare to the FY 2014 discharges provided in the Inpatient Discharge Database for pediatric patients age 6 months to 17 years (see table below).

HOSPITAL OF CENTRAL CONNECTICUT INPATIENT DISCHARGES
AGES 6 MONTHS to 17 YEARS OLD: FYs 2011 -2014

	DISCHARGES				PATIENT DAYS			
SERVICE LINE	FY 2011	FY 2012	FY 2013	**FY 2014**	FY 2011	FY 2012	FY 2013	FY 2014
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Maternity	47	44	50	**20**	130	112	149	47
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Pediatric	227	159	232	**144**	432	326	414	267
Medical/Surgical	67	61	57	**24**	146	114	110	52
Total	342	266	340	**190**	712	558	675	374

Source: *CT Department of Public Health Acute Care Hospital Inpatient Discharge Database*

Both HRS Report 400 and DPH Inpatient Discharge Database data include surgical patients which will not be impacted by the proposed CON.

HRS Report 400 was prepared using data based on the patient's physical location within the hospital and not based on the age of the patient. With low pediatric census, some adult medical/surgical patients were placed on the pediatric unit.

The DPH Inpatient Discharge Database is data taken directly from billing claim forms and includes all pediatric surgical cases.

The hospital reporting system reports age in years, not months.

Please see reconciliation below:

Discharges included in Chart	135
Surgical patients ages 1 day to 6 months	33
Subtotal DPH Inpatient Discharge Database	168
Adults on pediatric unit	38
HRS Report 400 Total	206

21. Will HOCC still have Maternity, Psychiatric or Surgical discharges for this age co-hort?

Yes. HOCC will continue to provide maternity and surgical discharges for this age co-hort. HOCC provides emergency psychiatric crisis evaluation in the emergency department for pediatric patients in this age co-hort, but only admits patients 18 and older to the inpatient unit.

EXHIBIT 11

TABLE 7

APPLICANT'S CURRENT & PROJECTED PAYER MIX

Inpatient Discharges

Payer	Current FY 2014**		Projected					
			FY 2015**		FY 2016**		FY 2017**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	0	0	0	0	0	0	0	0
Medicaid*	90	67.67	0	0	0	0	0	0
CHAMPUS & TriCare	1	0.75	0	0	0	0	0	0
Total Government	**91**	**68.42**	**0**	**0**	**0**	**0**	**0**	**0**
Commercial Insurers	39	29.32	0	0	0	0	0	0
Uninsured	3	2.26	0	0	0	0	0	0
Workers Compensation	0	0	0	0	0	0	0	0
Total Non-Government	**42**	**31.58**	**0**	**0**	**0**	**0**	**0**	**0**
Total Payer Mix	**133**	**100**	**0**	**0**	**0**	**0**	**0**	**0**

* Includes managed care activity.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

EXHIBIT 12

Revised Table 8 - Inpatient Pediatric Discharges

Inpatient Pediatric Discharges	
Town	Utilization FY 2014
Bristol	3
Farmington	1
Berlin	6
New Britain	92
Plainville	6
Windsor	1
Newington	2
Meriden	3
Plantsville	2
Southington	10
Waterbury	3
Wolcott	3
Naugatuck	1
Thomaston	1
Indian Head, MD	1
	135

REVISED TABLE 8 - Outpatient Pediatric Visits

Outpatient Pediatric Visits

Town	Utilization FY 2014
West Haven- CT	2
Harford- CT	45
Berlin- CT	35
West Hartford- CT	5
Bloomfield- CT	4
Hartford- CT	21
Bristol- CT	182
Manchester- CT	7
Burlington- CT	10
New Britain- CT	2
West Hartford- CT	9
Daytona Beach- FL	1
New Haven- CT	8
East Hartford- CT	19
West Hartford- CT	4
Farmington- CT	3
Mansfield- CT	1
Hartford- CT	146
Meriden- CT	51
Middletown- CT	17
Naugatuck- CT	5
New Britain- CT	4574
New Haven- CT	5
Newbury- VT	1
Philadelphia- PA	3
Plainville- CT	71
Southington- CT	7
Waterbury- CT	7
Portland- CT	2
Rocky Hill- CT	5
Simbury- CT	2
Simsbury- CT	3
Southington- CT	32
Suffield- CT	11
Wallingford- CT	9
Waterbury- CT	17
Waterbury- CT	18
	5344

EXHIBIT 13

The Hospital of Central Connecticut
Connect to healthier.™

August 2015

Dear Parent/Guardian of HOCC Pediatric Clinic Patient,

We would like to make you aware of some changes to our services at the clinic that will be taking place over the next six months.

The Hospital of Central Connecticut must continually evaluate how to provide safe, high-quality, cost-efficient care to all we serve. After careful consideration, and in light of declining volumes, we will no longer be providing pediatric care for inpatient and outpatient services, and will be providing you with the names of respected pediatric service providers and organizations in the community. Connecticut Children's Medical Center (Connecticut Children's) will be recommended for inpatient care, and we are working with our community pediatric providers, including Dr Noelle Leong and the Community Health Center of New Britain, to ensure that you, our pediatric patients, make an easy move to a new pediatric provider in the New Britain community.

At Connecticut Children's, pediatric patients will receive comprehensive and highly specialized care. Connecticut Children's has been named among the best for its pediatric care by *U.S. News & World Report* and is the only freestanding children's hospital in the state. In fact, Connecticut Children's already has a long history of serving patients in our community.

The Community Health Center of New Britain services the residents of the City of New Britain and offers a wide range of services including pediatric care, behavioral health, school-based health centers and dental care. In addition, there are pediatricians in our community whose practices are accepting new patients and who would be happy to serve as your provider. Please see the enclosed list of pediatricians who will be accepting new patients.

Once you have selected a new pediatrician or office for care, we can easily have your medical records transferred from the hospital clinic to your new provider. Please fill out the enclosed form and return it to the clinic or fax it to 860-224-5957. For telephone assistance please call XXX-XXX-XXXX (dedicated phone line will be established).

Your child is a valued patient in our Outpatient Pediatric Clinic. The decision to transition these services was taken very seriously with the intent to offer the highest level of care to our patients and for the communities we serve. We will continue to keep you updated with our plans. We thank you for the opportunity to care for your child.

Sincerely,

Annmarie Golloto MD
Attending Neonatologist
Director of Nurseries
Chief of Pediatrics

Hartford HealthCare
The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

*The Spanish translation will be completed pending CON approval.

EXHIBIT 14

The Hospital of Central Connecticut
Fee Schedule for Pediatric Clinic
FY 2015

Description	Price
LEVEL 1 VISIT PEDI NEW	139.00
LEVEL 2 VISIT PEDI NEW	191.00
LEVEL 3 VISIT PEDI NEW	251.00
LEVEL 4 VISIT PEDI NEW	269.00
LEVEL 5 VISIT PEDI NEW	348.00
LEVEL 1 NURSE VISIT PEDI EST.	110.00
LEVEL 2 VISIT PEDI EST	155.00
LEVEL 3 VISIT PEDI EST	212.00
LEVEL 4 VISIT PEDI EST	359.00
LEVEL 5 VISIT PEDI EST	450.00
12-17YRS PEDI NEW	228.00
12-17YRS PEDI EST	210.00
SCREENING VISION	122.00
SCREENING HEARING	122.00
PREVENT PEDI VISIT <1 YR NEW	179.00
PREVENT PEDI VISIT 1-4YRS NEW	203.00
PREVENT PEDI VISIT 5-11YRS NEW	203.00
PREVENT MED VISIT 12-17YRS NEW	228.00
PREVENT PEDI VISIT <1YR EST.	162.00
PREVENT PEDI VISIT 1-4YRS EST.	186.00
PREVENT PEDI VISIT 5-11YRS EST.	186.00
PREVENT MED VISIT 12-17YRS EST.	210.00
ADMIN OF SINGLE/COMBO VACCINATION	21.00
PPD	56.00
Urinalysis	20.00
Glucose	24.00

EXHIBIT 15

Applicant:

NON-PROFIT

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics

Financial Worksheet (A)

without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY 2014	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	864,609,377	838,089,000	($848,190)	$837,240,810	$813,777,000	($865,154)	$812,911,846	$805,441,000	($891,109)	$805,549,891	$804,788,000	($908,931)	$803,879,069
2	Less: Allowances	480,182,282	$494,373,000	($635,521)	$493,737,479	$463,574,818	($652,485)	$462,922,333	$455,018,235	($678,440)	$454,339,795	$449,691,006	($696,262)	$448,994,744
3	Less: Charity Care	17,256,889	$11,390,000		$11,390,000	$11,299,306		$11,299,306	$11,235,310		$11,235,310	$11,226,453		$11,226,453
4	Less: Other Deductions	0			$0			$0			$0			$0
	Net Patient Service Revenue	367,170,206	$332,326,000	($212,669)	$332,113,331	$338,902,876	($212,669)	$338,690,207	$340,187,455	($212,669)	$339,974,786	$343,870,541	($212,669)	$343,657,872
5	Medicare	138,054,052	$124,952,815		$124,952,815	$127,425,686		$127,425,686	$127,908,681		$127,908,681	$129,293,501		$129,293,501
6	Medicaid	59,639,703	$53,979,935	($212,669)	$53,767,266	$55,048,222	($212,669)	$54,835,553	$55,256,877	($212,669)	$55,044,208	$55,855,123	($212,669)	$55,642,454
7	CHAMPUS & TriCare	282,264	$255,477		$255,477	$260,533		$260,533	$261,521		$261,521	$264,352		$264,352
8	Other	0			$0			$0			$0			$0
	Total Government	197,976,019	$179,188,228	($212,669)	$178,975,559	$182,734,441	($212,669)	$182,521,772	$183,427,078	($212,669)	$183,214,409	$185,412,976	($212,669)	$185,200,307
9	Commercial Insurers	150,846,850	$136,531,585		$136,531,585	$139,233,604.65		$139,233,605	139,761,356		$139,761,356	141,274,502		$141,274,502
10	Uninsured				$0			$0			$0			$0
11	Self Pay	8,818,166	$7,981,328		$7,981,328	$8,139,281.92		$8,139,282	8,170,133		$8,170,133	8,258,588		$8,258,588
12	Workers Compensation	5,499,389	$4,977,501		$4,977,501	$5,076,007.58		$5,076,008	5,095,248		$5,095,248	5,150,412		$5,150,412
13	Other	4,029,782	$3,647,358		$3,647,358	$3,719,541.20		$3,719,541			$0			$0
	Total Non-Government	169,194,187	$153,137,772	$0	$153,137,772	$156,168,435	$0	$156,168,435	$153,026,737	$0	$153,026,737	$154,683,502	$0	$154,683,502
	Net Patient Service Revenue[a] (Government+Non-Government)	367,170,206	$332,326,000	($212,669)	$332,113,331	$338,902,876	($212,669)	$338,690,207	$336,453,815	($212,669)	$336,241,146	$340,096,478	($212,669)	$339,883,809
14	Less: Provision for Bad Debts	5,458,239	$6,175,000		$6,175,000	$6,126,847		$6,126,847	$6,092,146		$6,092,146	$6,087,343		$6,087,343
	Net Patient Service Revenue less provision for bad debts	361,711,967	$326,151,000	($212,669)	$325,938,331	$332,776,029	($212,669)	$332,563,360	$334,095,309	($212,669)	$333,882,640	$337,783,198	($212,669)	$337,570,529
15	Other Operating Revenue	11,024,317	$15,152,000		$15,152,000	$15,912,000		$15,912,000	$16,289,000		$16,289,000	$16,676,000		$16,676,000
17	Net Assets Released from Restrictions	1,351,596	$1,400,000		$1,400,000	$1,416,000		$1,416,000	$1,465,000		$1,465,000	$1,517,000		$1,517,000
	TOTAL OPERATING REVENUE	374,087,880	$342,703,000	($212,669)	$342,490,331	$350,104,029	($212,669)	$349,891,360	$351,849,309	($212,669)	$351,636,640	$355,976,198	($212,669)	$355,763,529
B.	OPERATING EXPENSES													
1	Salaries and Wages	148,416,218	$138,379,000	($701,601)	$137,677,399	$141,541,000	($719,141)	$140,821,859	$145,221,000	($740,715)	$144,480,285	$150,014,000	($755,529)	$149,258,471
2	Fringe Benefits	45,122,344	$41,719,000	($162,000)	$41,557,000	$42,387,000	($162,000)	$42,225,000	$43,526,000	($162,000)	$43,364,000	$44,986,000	($165,000)	$44,821,000
3	Physicians Fees	9,980,614	$10,180,000		$10,180,000	$10,000,000		$10,000,000	$10,025,000		$10,025,000	$10,056,000		$10,056,000
4	Supplies and Drugs	49,864,651	$35,915,000		$35,915,000	$39,331,000		$39,331,000	$39,669,000		$39,669,000	$41,526,000		$41,526,000
5	Depreciation and Amortization	18,225,335	$19,460,000		$19,460,000	$14,085,000		$14,085,000	$12,103,000		$12,103,000	$10,641,000		$10,641,000
6	Provision for Bad Debts-Other[b]	0	$0		$0			$0			$0			$0
7	Interest Expense	1,418,199	$3,268,000		$3,268,000	$3,221,000		$3,221,000	$3,219,000		$3,219,000	$3,087,000		$3,087,000
8	Malpractice Insurance Cost	3,957,824	$3,635,000		$3,635,000	$3,748,000		$3,748,000	$3,860,000		$3,860,000	$3,168,000		$3,168,000
9	Lease Expense		$0		$0			$0	$0		$0	$0		$0
10	Other Operating Expenses	82,318,899	$81,400,000		$81,400,000	$83,005,000		$83,005,000	$80,487,000		$80,487,000	$78,616,000		$78,616,000
	TOTAL OPERATING EXPENSES	359,304,084	$333,956,000	($863,601)	$333,092,399	$337,318,000	($881,141)	$336,436,859	$338,110,000	($902,715)	$337,207,285	$342,094,000	($920,529)	$341,173,471
	INCOME/(LOSS) FROM OPERATIONS	14,783,796	$8,747,000	$650,932	$9,397,932	$12,786,029	$668,472	$13,454,501	$13,739,309	$690,047	$14,429,356	$13,882,198	$707,860	$14,590,058
	NON-OPERATING REVENUE	9,562,104	$2,000,000		$2,000,000	$5,000,000		$5,000,000	$5,000,000		$5,000,000	$5,000,000		$5,000,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	24,345,900	$10,747,000	$650,932	$11,397,932	$17,786,029	$668,472	$18,454,501	$18,739,309	$690,047	$19,429,356	$18,882,198	$707,860	$19,590,058
	Principal Payments	2,329,000	$2,100,000		$2,100,000	$1,950,000		$1,950,000	$1,800,000		$1,800,000	$1,700,000		$1,700,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	3.85%	2.5%	-306.1%	2.7%	3.6%	-314.3%	3.8%	3.9%	-324.5%	4.0%	3.8%	-332.8%	4.0%
2	Hospital Non Operating Margin	2.49%	0.6%	0.0%	0.6%	1.4%	0.0%	1.4%	1.4%	0.0%	1.4%	1.4%	0.0%	1.4%
3	Hospital Total Margin	6.35%	3.1%	-306.1%	3.3%	5.0%	-314.3%	5.2%	5.3%	-324.5%	5.4%	5.2%	-332.8%	5.4%
D.	FTEs	1,894	1,788	(6)	1,782	1,788	(6)	1,782	1,788	(6)	1,782	1,788	(6)	1,782
E.	VOLUME STATISTICS[c]													
1	Inpatient Discharges	15,640	14,750		14,750	14,750		14,750	14,750		14,750	14,750		14,750
2	Outpatient Visits	403,498	411,568	(3,500)	408,068	415,684	(3,500)	412,184	417,762	(3,500)	414,262	418,806	(3,500)	415,306
	TOTAL VOLUME	419,138	426,318	(3,500)	422,818	430,434	(3,500)	426,934	432,512	(3,500)	429,012	433,556	(3,500)	430,056

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT 16

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
Outpatient Pediatric Clinic	New Britain, CT	1710983937 1013939867 1598864217	Community Health Center 85 Lafayette Street New Britain, CT 06051` Multiple providers	M-Th: 8:00 AM -6:30 PM Friday: 8:00 AM -5:00 PM Saturday: 8:00 AM – 4:00 PM	Unknown
Community Pediatricians	New Britain, CT	1386694750	Phillips Foster, MD 40 Hart Street New Britain, CT 06051	M, T, Th: 9:00 AM -3:00 PM	Unknown
		1316943285	Grove Hill Medical Center 300 Kensington Avenue New Britain, CT 06051	M-F: 8:30 AM -5:00 PM Weekend by appointment	Unknown
		Unknown	184 East Street Plainville, CT 06062 Multiple providers	M-F: 9:00 AM -4:30 PM Weekend by appointment	Unknown
		1588699235	New Britain Pediatric Group 1095 West Main Street New Britain, CT 06053 Multiple providers	M-F:9:00 AM -4:30PM	Unknown
		1528120094	Personal Care Pediatrics 340 North Main Street Southington, CT 06489	M-TH 9:00 AM -5:00PM F-9:00AM -3:00PM	Unknown
		1811994007	Pediatric Care Center 780 Farmington Ave Bristol, CT 06010	M,W,TH,F 8:30AM-5PM T 8:30AM -7:00PM	Unknown
		1467519793	Berlin Pediatric Associates 742 Worthington Rd Suite A Berlin, CT 06037	M-F 7:00AM-4:00PM Sat 8:00AM-11:00AM	Unknown
		1649286766	Mark Peterson, MD 143 North Main Street Southington,CT 06489	M-F 9:00AM-5:00PM	Unknown
		1184647380	Alpa Patel, MD 710 Main Street, Building 1 Plantsville, CT 06479	M-W 8:00AM-5:00PM TH 8:00AM- 12noon F 8:00AM-3:00PM	Unknown

		1760579296 1760579296	George Skarvinko, MD Southington Pediatric Associates 209 Main Street Suite A Southington,CT 06489 Teresa M. Szajda, MD 7 North Washington Street, Suite 109 Plainville, CT 06062	M-F 8:00AM-5:00PM M,T,TH,F 8:00AM-5:00PM Closed Wednesday	Unknown

*** Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider** Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

EXHIBIT 17

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016*	FY 2017*	FY 2018*
Revenue from Operations	($212,669.00)	($212,669.00)	($212,669)
Total Operating Expenses	($863,601.00)	($881,141.00)	($902,715.00)
Gain/Loss from Operations	$650,932.00	$668,472.00	$690,047.00

* Fill in years using those reported in the Financial Worksheet attached.

Huber, Jack

From: Huber, Jack
Sent: Friday, October 23, 2015 2:59 PM
To: Durdy, Barbara (Barbara.Durdy@hhchealth.org)
Cc: Roberts, Karen; Foster, Tillman
Subject: HOCC's CON Application to Terminate Pediatric Services, DN 15-32023-CON
Attachments: DN 32023 Completeness Notification.pdf

Good afternoon Barbara – I trust this email finds you well.

Today the Office of Health Care Access ('OHCA") deemed the above referenced CON application complete. OHCA's website has been updated to reflect the change in the CON application's status. Attached is a copy of OHCA's notification letter deeming the CON application complete.

As OHCA prepares to coordinate with you the scheduling of a public hearing in this matter, it is important to note that the hearing needs to be scheduled in the community where the proposed service termination is to take place. The Applicant selects a hearing site that will be conducive to the expected turn out for the public hearing. The date for the public hearing is arranged in agreement with OHCA and the Applicant. Here are some of the general operating parameters with respect to the scheduling of the public hearing in this matter:

1. Timing Aspects:
    a. Generally OHCA prefers the scheduling of the public hearing on Tuesday, Wednesdays or Thursdays.
    b. The hearing room should be reserved for use between the hours of 4:00 pm and 8:00 pm with an intended start time of 5:00 pm.
    c. In recognition of public notification requirements the scheduling window for this hearing would be optimal for the third full week in November – November 17, 18, or 19th.

2. Considerations OHCA will need to establish:
    a. Prospective Date & Hearing Location (address, building and/or room designation).
    b. Directions to the hearing site.
    c. The application's contact person for Barbara Olejarz, if the person is to be someone other than yourself.

Please feel free to contact me to discuss matters relating to the scheduling of this public hearing. Thank you.

Jack A. Huber, Health Care Analyst
CT Department of Public Health | Office of Health Care Access |410 Capitol Avenue
P.O. Box 340308, MS #13HCA | Hartford, CT 06134-0308|Ph: 860-418-7069|Fax: 860-418-7053
Email: Jack.Huber@ct.gov |Web: www.ct.gov/ohca

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 23, 2015

VIA EMAIL ONLY

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare Corporation
181 Patricia M. Genova Blvd.
Newington, CT 06111

RE: Certificate of Need Application; Docket Number: 15-32023-CON
The Hospital of Central Connecticut's Proposal to Terminate its Inpatient & Outpatient Pediatric Services at its New Britain General Campus
Notification Deeming the CON Application Complete

Dear Ms. Durdy:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of October 23, 2015.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7069 or Tillman Foster at (860) 418-7031.

Sincerely,

Jack A. Huber

Jack A. Huber
Health Care Analyst

Greer, Leslie

From: Greer, Leslie
Sent: Monday, November 09, 2015 4:49 PM
To: 'barbara.durdy@hhchealth.org'
Cc: Huber, Jack; Foster, Tillman; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Casagrande, Antony A; Furniss, Wendy; Gerrish, William; Kennedy, Jill; Stan, Christopher; Ward, DeVaughn; Marielle Daniels
Subject: HOCC Hearing Notice
Attachments: 32023.pdf

Tracking:

Recipient	Delivery
'barbara.durdy@hhchealth.org'	
Huber, Jack	Delivered: 11/9/2015 4:49 PM
Foster, Tillman	Delivered: 11/9/2015 4:49 PM
Riggott, Kaila	Delivered: 11/9/2015 4:49 PM
Hansted, Kevin	Delivered: 11/9/2015 4:49 PM
Martone, Kim	Delivered: 11/9/2015 4:49 PM
Casagrande, Antony A	Delivered: 11/9/2015 4:49 PM
Furniss, Wendy	Delivered: 11/9/2015 4:49 PM
Gerrish, William	Delivered: 11/9/2015 4:49 PM
Kennedy, Jill	Delivered: 11/9/2015 4:49 PM
Stan, Christopher	Delivered: 11/9/2015 4:49 PM
Ward, DeVaughn	Delivered: 11/9/2015 4:49 PM
Marielle Daniels	

Ms. Durdy,
Attached is the hearing notice for The Hospital of Central Connecticut's hearing scheduled for December 2, 2015 @ 5:00 p.m.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 10, 2015

Barbara A. Durdy
Director, Strategic Planning
The Hospital of Central Connecticut
181 Patricia M. Genova Blvd.
Newington, CT 06111

RE: Certificate of Need Application, Docket Number 15-32023-CON
The Hospital of Central Connecticut
Termination of The Hospital of Central Connecticut's Inpatient and Outpatient Pediatric Services

Dear Ms. Durdy,

With the receipt of the completed Certificate of Need ("CON") application information submitted by The Hospital of Central Connecticut ("Applicant") on October 23, 2015, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	The Hospital of Central Connecticut
Docket Number:	15-32023-CON
Proposal:	Termination of The Hospital of Central Connecticut's Inpatient and Outpatient Pediatric Services

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: December 2, 2015

Time: 5:00 p.m.

Place: New Britain High School – Lecture Hall
110 Mill Street
New Britain, CT 06051

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Herald* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
William Gerrish, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:JAH:TF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 10, 2015 P.O. #54772

The Herald
1 Herald Square
New Britain, CT 06050

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, November 11, 2015**. Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:JAH:TF:lmg

The Herald **November 10, 2015**
Notice of Public Hearing, Docket Number 15-32023-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	The Hospital of Central Connecticut
Town:	New Britain
Docket Number:	15-32023-CON
Proposal:	Termination of The Hospital of Central Connecticut's Inpatient and Outpatient Pediatric Services
Date:	December 2, 2015
Time:	5:00 p.m.
Place:	New Britain High School – Lecture Hall 110 Mill Street New Britain, CT 06051

Any person who wishes to request status in the above listed public hearing may file a written petition no later than November 27, 2015 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Monday, November 09, 2015 4:22 PM
To: Greer, Leslie
Subject: Re: DN: 15-32023-CON Hearing Notice

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

Don't forget to ask for ideas to expand your diversity coverage.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, November 9, 2015 4:02 PM
To: ads <ads@graystoneadv.com>
Subject: DN: 15-32023-CON Hearing Notice

Please run the attached hearing notice in The Herald by November 11, 2015. For billing purposes, refer to P.O. # 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Durdy, Barbara <Barbara.Durdy@hhchealth.org>
Sent: Tuesday, November 10, 2015 10:20 AM
To: Greer, Leslie
Cc: Huber, Jack; Foster, Tillman; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Casagrande, Antony A; Furniss, Wendy; Gerrish, William; Kennedy, Jill; Stan, Christopher; Ward, DeVaughn; Marielle Daniels
Subject: RE: HOCC Hearing Notice

Thank you Leslie.
We are all set on our end.

Barbara A. Durdy
Director, Strategic Planning

Hartford HealthCare

181 Patricia M. Genova Blvd.

Newington, CT 06111

Office: 860.972.4231

Cell: 203.859.8174

barbara.durdy@hhchealth.org

www.hartfordhealthcare.org

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Monday, November 09, 2015 4:49 PM
To: Durdy, Barbara
Cc: Huber, Jack; Foster, Tillman; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Casagrande, Antony A; Furniss, Wendy; Gerrish, William; Kennedy, Jill; Stan, Christopher; Ward, DeVaughn; Marielle Daniels
Subject: HOCC Hearing Notice

Ms. Durdy,
Attached is the hearing notice for The Hospital of Central Connecticut's hearing scheduled for December 2, 2015 @ 5:00 p.m.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Tuesday, November 10, 2015 1:11 PM
To: Greer, Leslie
Subject: FW: DN: 15-32023-CON Hearing Notice
Attachments: 15-32023np Herald.doc

Good afternoon,

This notice is set to publish tomorrow.
$460.91

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Mon, 9 Nov 2015 16:21:35 -0500
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN: 15-32023-CON Hearing Notice

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, November 9, 2015 4:02 PM
To: ads <ads@graystoneadv.com>
Subject: DN: 15-32023-CON Hearing Notice

Please run the attached hearing notice in The Herald by November 11, 2015. For billing purposes, refer to P.O. # 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Industrial Space 741

BRISTOL - 460 sf, $400. 800 sf, $600. 1500 sf, $750. 6000 sf, $3000. Central Bristol. 860-729-1010.

Legals 0900

NOTICE OF SALE

EZ Storage will sell the contents of the following units at a public sale for cash only if payment is not received. Auction to be held online at http://www.storagetreasures.com beginning Wednesday November 11, 2015 at 10:00am and ending Wednesday November 18, 2015 at 10:00am.

James Dierichsen a/k/a Dietrichsen #243 - fishing pole, safe furniture, household items.

Michele Kasparian #040 - luggage, exercise machine, plastic tubs, furniture.

Sylvio Libby #110 - slot machine, bike, records, household.

Any parties having interest in said units or to make payment, may call 860-620-9030.

Owner reserves the right to reject any/all bids, cancel or adjourn sale.

For more information or to resolve this claim, please contact the manager at EZ Storage 751 West Queen St. Southington CT. 06489 860-620-9030

ANNOUNCEMENTS 105-130

Found 125

FOUND DOG - Young female Cattle/Pit Bull X. Found on Hatch St in New Britain. 860-667-9363, ask for Diane or Kyle.

FOUND SM ROSETTI COIN PURSE - Describe contents. (860) 628-7117.

MERCHANDISE 203-299

Miscellaneous 278

TAG SALE PRICES! New body washes, shampoo/conditioner, razors, deodorant, powder. $3 ea. 860-225-5986.

Wood/Woodstoves 296

QUADRA-FIRE CB2000 Wood pellet stove w/insert in gd running cond, $425 cash only. Price inc 43 40 lb bags of hw pellets. 860-805-4090, between 5:30pm - 9:30pm all week.

Wanted to Buy 299

ALWAYS ACQUIRING all vintage musical instruments, guitars, amps, trumpets, saxophones, accordions. Cash paid. 860-372-9147.

ALWAYS BUYING - Vintage electronics, Ham, CB, shortwave, radios, guitars, amps, hi-fi audio, watches. 860-707-9350.

ANTIQUES. Always buying, cash paid. One item or entire estate. Clocks, military, cameras, watches, toys, posters, art, jewelry, signs, musical instruments & more. 860-718-5132.

BUSINESS / FINANCIAL 405-430

Business Opportunities 410

Entrepreneurs wanted! Property and Casualty Insurance Agency for Sale. Affiliated with major national carrier. Great business opportunity! Please Contact Scott Trice
E: jstrice@sbcglobal.net
P: (860) 207-4891

EMPLOYMENT 505-535

Help Wanted 520

Angelo's Market is now hiring.
Experience Required
Positions
Chef
Cashier
Deli Help
21 or older.
Must be flexible for mornings & afternoons.
Apply within.
349 West Main Street
New Britain

EXP'D SHEETMETAL & STEEL ERECTORS-Exp preferred, but willing to train. 207-416-6022

GENERAL MAINTENANCE/CUSTODIAN - FT or PT. Good benefits for FT. Email: bfdesign@bfdesigninc.com

PET SITTING SERVICE Looking for pet lovers. All shifts avail. Must have own transportation & be reliable. Earn $16+/hour. Apply: www.waggingtails.com

AUTOMOTIVE 605-660

Autos for Sale 615

JEEP, GRAND CHEROKEE LTD, 2004; Leather power heated seats, 6 cyl, new tires & front brakes, stereo, power sunroof, gd cond. 860-830-1059.

Trucks/SUVs/Vans 620

CHRYSLER, PT CRUISER, 2003: Original owner, runs good, many new parts. Mechanic's special. Needs work. Test-drive it. $1500/BO. 860-839-2582, 6pm - 8pm. kman255@msn.com

Tires/Parts/Accessories 645

TACOMA LONGBED CARGO CAP - w/bed extender. $300. 860-989-2134

REAL ESTATE FOR RENT 705-765

Apartments for Rent 720

#1 BRISTOL - 1st FL, 2 BR, close to hwy. Laundry rm on site. **NO PETS.** 860-559-9349 RE Agent.

NEW BRITAIN - 2 BR, 1st FL, gar. Wood flrs, no pets. 860-966-8963.

NEW BRITAIN - Allen St, 1 BR, inc ht/hw/cooking gas, appl. $675. Lg studio, Whiting St, $575. **No pets.** 860-826-6757.

NEW BRITAIN
APPLICATIONS BEING ACCEPTED FOR
3 & 4 BR'S STARTING AT $1045.00
INCOME RESTRICTIONS APPLY.
INDUSTRIA COMMONS & BRYTANIA SQUARE
(860)612-0100.

NEW BRITAIN - Real nice 1 BR. Ref & sec req'd. 860-518-0158.

Condominiums 730

*** BRISTOL/FARMINGTON LINE -** 3 RM, all appl inc w/d. Full basement. $850. **NO PETS.** 860-559-9349 RE Agent.

Condominiums 730

*** BRISTOL/FARMINGTON LINE -** Spac end unit, 4 RM, all appl inc w/d. Basement stor. $950. **NO PETS.** 860-559-9349 RE Agent.

Garage/Space/Land 750

STORAGE CONTAINERS FOR RENT. 40 ft long, 8 ft wide, 8 ft high. $150.00/month. 860-874-2474 or 860-729-1010.

Mobile Homes 755

PLAINVILLE - Next to town park. 2 BR, 1 BA, lg eat-in kitchen, shed. $24,000. Liberty Mobile Homes (860)747-6881

SUDOKU

						9		
			1		7	4	2	
5		9		2			1	
	6	4	9		8		3	2
1	2		6		3	5	4	
	5			1		7		4
	3	6	7		4			
		1						

See Sudoku solution on TV page.

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	The Hospital of Central Connecticut
Town:	New Britain
Docket Number:	15-32023-CON
Proposal:	Termination of The Hospital of Central Connecticut's Inpatient and Outpatient Pediatric Services
Date:	December 2, 2015
Time:	5:00 p.m.
Place:	New Britain High School – Lecture Hall 110 Mill Street New Britain, CT 06051

Any person who wishes to request status in the above listed public hearing may file a written petition no later than November 27, 2015 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Clay R. Pollan's

THAT DAILY PUZZLER SCRAM-LETS® **WORD GAME**

Edited by Ray & Rosemary Gray

1 Rearrange letters of the four scrambled words below to form four simple words.

K E S H T C
1 2

P A L C M
3 4

T H I S G
5 6

T A B K E S
7 8

11/11/15

An old timer once told me that one skill that most people seem to be born with is that of making _____.

4 Complete the chuckle quoted by filling in the missing words you develop from step No.3 below.

2 PRINT NUMBERED LETTERS IN SQUARES: 1 2 3 4 5 6 7 8

3 UNSCRAMBLE FOR ANSWER

SCRAMLETS ANSWERS 11/11/15

sketch - clamp - sight - basket - mistakes

An old timer once told me that one skill that most people seem to be born with is that of making MISTAKES.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: November 10, 2015

RE: Certificate of Need Application; Docket Number: 15-32023-CON
The Hospital of Central Connecticut
Termination of Inpatient and Outpatient Pediatric Services at the New Britain General Hospital Campus

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Huber, Jack

From: Huber, Jack
Sent: Friday, November 13, 2015 2:28 PM
To: Durdy, Barbara (Barbara.Durdy@hhchealth.org)
Cc: Roberts, Karen; Foster, Tillman
Subject: Letter Requesting Prefiled Testimony & Response to Issues; DN 15-32023-CON
Attachments: 15-32023_Prefiled Testimony Request.pdf; 15-32023 Issues.docx

Good afternoon Ms. Durdy – Please find attached a PDF version of OHCA's letter requesting prefiled testimony and issue responses for the public hearing scheduled for Wednesday, December 2, 2015 in the matter of The Hospital for Central Connecticut's proposal to terminate inpatient pediatric and pediatric outpatient clinic services. Also attached is a Word version of the issues that you may wish to use in preparation of your issues response. Please feel free to contact me or Tillman Foster if you have any questions regarding the attached documents. Thank you. Regards, Jack

Jack A. Huber, Health Care Analyst
CT Department of Public Health | Office of Health Care Access |410 Capitol Avenue
P.O. Box 340308, MS #13HCA | Hartford, CT 06134-0308|Ph: 860-418-7069|Fax: 860-418-7053
Email: Jack.Huber@ct.gov |Web: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 13, 2015

VIA EMAIL ONLY

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare Corporation
181 Patricia M. Genova Blvd.
Newington, CT 06111

RE: Certificate of Need Application; Docket Number: 15-32023-CON
The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services
Letter Requesting Prefiled Testimony

Dear Ms. Durdy:

The Office of Health Care Access ("OHCA") will hold a public hearing on Wednesday, December 2, 2015 starting at 5:00 p.m. at the New Britain High School, Lecture Hall, 110 Mill Street, New Britain, CT regarding the Certificate of Need ("CON") application identified above. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. The Applicant's prefiled testimony must be submitted to OHCA by 12:00 p.m. **on Tuesday, November 24, 2015.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please respond to the attached Issues in writing to OHCA **on November 24, 2015.**

Please contact Jack A. Huber at (860) 418-7069 or Tillman Foster (860) 418-7031 if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

Issues

Certificate of Need Application; Docket Number: 15-32023-CON

Hospital of Central Connecticut ("Hospital")

Proposal to Terminate the Hospital's Inpatient and Outpatient Pediatric Services

The Hospital should be prepared to present and discuss supporting evidence on the following issues:

1. Describe how the proposal will improve access to care for pediatric inpatients and clinic outpatients that have been or that are currently being treated by the Hospital.

2. Discuss the quality enhancements to be derived by pediatric patients when they have been transitioned to the earmarked inpatient, community-based and primary care programs that will continue to provide health care services to these individuals.

3. In a scenario the Hospital offered in its completeness response, pediatric patients requiring inpatient care would be triaged and stabilized in the Emergency Department ("ED") before being transported to the Connecticut Children's Medical Center for continuing care. Explain further how such an event would not generate an ED charge on the part of Hospital.

4. Discuss the treatment/protocol ramifications of pediatric patients presenting to the Hospital's ED after hours after the proposed terminations have occurred.

5. Describe the affect the proposal will have on the Hospital's continuing pediatric surgical program?

Issues

Certificate of Need Application; Docket Number: 15-32023-CON

Hospital of Central Connecticut ("Hospital")

Proposal to Terminate the Hospital's Inpatient and Outpatient Pediatric Services

The Hospital should be prepared to present and discuss supporting evidence on the following issues:

1. Describe how the proposal will improve access to care for pediatric inpatients and clinic outpatients that have been or that are currently being treated by the Hospital.

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4. Discuss the treatment/protocol ramifications of pediatric patients presenting to the Hospital's ED after hours after the proposed terminations have occurred.

5. Describe the affect the proposal will have on the Hospital's continuing pediatric surgical program?

Huber, Jack

From: Durdy, Barbara <Barbara.Durdy@hhchealth.org>
Sent: Friday, November 13, 2015 3:46 PM
To: Huber, Jack
Cc: Roberts, Karen; Foster, Tillman
Subject: RE: Letter Requesting Prefiled Testimony & Response to Issues; DN 15-32023-CON

Thank you Jack. We will make sure we address these issues in the prefile.
Thank you
Enjoy the weekend,
Barbara

Barbara A. Durdy
Director, Strategic Planning

Hartford HealthCare

Hartford HealthCare

181 Patricia M. Genova Blvd.

Newington, CT 06111

Office: 860.972.4231

Cell: 203.859.8174

barbara.durdy@hhchealth.org

www.hartfordhealthcare.org

From: Huber, Jack [mailto:Jack.Huber@ct.gov]
Sent: Friday, November 13, 2015 2:30 PM
To: Durdy, Barbara
Cc: Roberts, Karen; Foster, Tillman
Subject: Letter Requesting Prefiled Testimony & Response to Issues; DN 15-32023-CON

Good afternoon Ms. Durdy – Please find attached a PDF version of OHCA's letter requesting prefiled testimony and issue responses for the public hearing scheduled for Wednesday, December 2, 2015 in the matter of The Hospital for Central Connecticut's proposal to terminate inpatient pediatric and pediatric outpatient clinic services. Also attached is a Word version of the issues that you may wish to use in preparation of your issues response. Please feel free to contact me or Tillman Foster if you have any questions regarding the attached documents. Thank you. Regards, Jack

Jack A. Huber, Health Care Analyst
CT Department of Public Health | Office of Health Care Access |410 Capitol Avenue
P.O. Box 340308, MS #13HCA | Hartford, CT 06134-0308|Ph: 860-418-7069|Fax: 860-418-7053
Email: Jack.Huber@ct.gov |Web: www.ct.gov/ohca

Greer, Leslie

From: Huber, Jack
Sent: Tuesday, November 24, 2015 11:45 AM
To: Roberts, Karen; Hansted, Kevin
Cc: Riggott, Kaila; Greer, Leslie; Olejarz, Barbara; Foster, Tillman
Subject: FW: HOCC-Docket No. 15-32023-CON
Attachments: Notice of Appearance.pdf; Prefiled Testimony.pdf

Dear All – Attached is HOCC's prefiled hearing testimony and notice of appearance with cover. Jack

---

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Tuesday, November 24, 2015 11:37 AM
To: Huber, Jack; Foster, Tillman
Cc: Durdy, Barbara (Barbara.Durdy@hhchealth.org); Goyette, Karen T.
Subject: HOCC-Docket No. 15-32023-CON

Jack and Tillman:
Attached is my notice of appearance along with our Pre-filed Testimony for the hearing to be held on Dec. 2, 2015. I will be hand delivering you 5 copies of the bate stamped originals within the next hour.
Many thanks and Happy Thanksgiving.
Best.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman, Esq.
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 24, 2015

VIA HAND DELIVERY

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: **IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS**
DOCKET NO: 15-32023-CON

Dear Ms. Martone:

Enclosed please find an original and five copies of our Pre-Filed Testimony of Annemarie Golioto, M.D., on behalf of the Applicant regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Jwf/tja
Enclosure
4431393v1

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

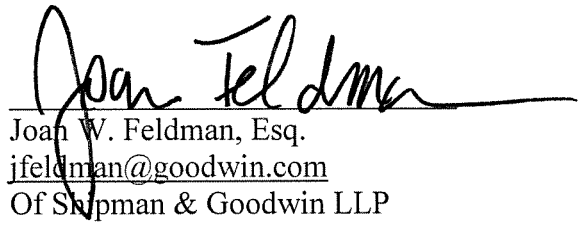
IN THE MATTER OF THE	**:**	**DOCKET NO. 13-31851-CON**
ESTABLISHMENT OF AN ORTHOPEDIC	**:**	
AMBULATORY SURGERY CENTER ON	**:**	
THE HARTFORD HOSPITAL CAMPUS	**:**	**DECEMBER 2, 2015**

PRE-FILED TESTIMONY OF ANNMARIE GOLIOTO, M.D., CHIEF OF PEDIATRICS, THE HOSPITAL OF CENTRAL CONNECTICUT

Accompanying this cover sheet is the pre-filed testimony of Annemarie Golioto, M.D. on behalf of the Applicant in the above-captioned application.

Respectfully Submitted,

The Hospital of Central Connecticut

By: 

Joan W. Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Its Attorney

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS	:	**DOCKET NO. 15-32023-CON**
	:	
	:	
	:	**December 02, 2015**

PRE-FILED TESTIMONY OF ANNMARIE GOLIOTO, M.D., CHIEF OF PEDIATRICS, THE HOSPITAL OF CENTRAL CONNECTICUT

Good evening, staff of the Office of Health Care Access ("OHCA"). My name is Annmarie Golioto, M.D., and I am an Attending Neonatologist, Director of Nurseries, and Chief of Pediatrics at The Hospital of Central Connecticut ("HOCC" or "Hospital"). I am grateful to have this opportunity to personally speak with you today and convey my reasons for recommending to OHCA that it approve the above-referenced application (the "Application") to terminate HOCC's inpatient and outpatient pediatric programs (the "Programs").

As I have been caring for children for almost twenty (20) years, it is only natural that I feel a great deal of sadness that I am before you today with this proposal. I came to HOCC in 2013 as the Medical Director of the HOCC Nurseries and I have both witnessed and I have been informed by my colleagues of HOCC's efforts to manage and sustain these very Programs. Nevertheless, it has become quite evident to me that the continued viability and sustainability of these Programs is no longer in the best interests of the HOCC community. It is my hope that with my pre-filed testimony that I will be able to clearly articulate all the reasons why this Application should be approved by OHCA.

1. **Evolution of Inpatient Pediatric Care in the Community.** As we stated in greater detail in the Application, medical advances in the treatment of children, along

with improved management of children's health care needs on an outpatient basis, has had a positive and significant impact on the number of children needing inpatient hospital services. See Exhibit 3 at pages 0045 to 0069 of the Application. This is a very good development of course, but the collateral effect has been a significant reduction in the number of low complexity inpatient admissions, which are the type of inpatient pediatric cases cared for at HOCC. Moreover and as also stated in the Application, the children that do in fact require inpatient services are generally more acutely ill with chronic medical conditions that typically involve multiple comorbidities. See pages 0012 to 0014 of the Application. These more acutely ill children benefit from the full range and complement of specialized services offered by a specialty children's hospital, but not typically offered at a community hospital like HOCC. For example, in a children's specialty hospital, pediatric subspecialty physicians are available to address the special medical complexities of children, along with all of the ancillary services normally associated with the delivery of care to children such as, specialized pediatric testing modalities, pediatric nutritionists and pharmacists, physical therapy, occupational therapy, speech therapy, behavioral health, and child life services, to name a few. Therefore, it is my professional opinion, that children who require inpatient care, (typically children that are more acutely ill), need the expertise and specialized range and complement of ancillary services that a specialty children's hospital can offer.

2. <u>Efforts Made by HOCC to Sustain its Inpatient Pediatric Program</u>.

To date, and as stated in the Application, HOCC has been very committed to sustaining its pediatric inpatient service. As children requiring inpatient admission have more complex medical needs, inpatient management has become in many ways its own

specialized service as opposed to the historically common model of community pediatricians providing the oversight and management of the inpatient care provided to their patients. As HOCC's inpatient volumes began to decline, HOCC looked for alternative ways to maintain, and grow its inpatient pediatric service. Thus, in 2012, HOCC decided to hire two pediatric hospitalists for the purpose of providing full-time coverage to the pediatric patients who were requiring inpatient care. With this hospitalist service, community pediatricians had the option of referring patients needing inpatient care to the hospitalist-run pediatric service at HOCC, admitting their patient to the HOCC inpatient service under their own care, or referring their patient directly to Connecticut Children's Medical Center ("CCMC"). It has been our experience that community pediatricians chose to either admit to the hospitalist-run service or transfer their patient directly to CCMC depending on the complexity of the patient.

Unfortunately, the benefits of providing the hospitalist coverage did not yield an increase in inpatient admissions to HOCC that would be necessary to sustain the service, and the HOCC inpatient service remained underutilized, leaving the pediatric hospitalists idle. As a consequence, both of the pediatric hospitalists, seeing the proverbial writing on the wall, left the community to secure more challenging positions. Without the demand or volume to justify the program, the pediatric hospitalist program was eliminated by HOCC in 2014. Since that time, HOCC affiliated community pediatricians (with admitting privileges) continue to have the ability to admit and manage their patients on HOCC's pediatric unit should they so choose.

HOCC continues to maintain pediatric nursing coverage in the event that community pediatricians decide to admit their patients, but there has, in fact, been little to

no demand for such nursing services. Given the infrequency of use of these pediatric inpatient services, it is my opinion that continuation of this pediatric inpatient service is not in the best interest of the community we serve. Such a low volume service cannot adequately maintain the nursing and medical competencies that the patients deserve. More specifically, it is my belief that should a child from our community require pediatric inpatient services, it is in their best interest to receive their care from a pediatric specialty hospital, one that is fully staffed with clinicians who have the competencies to deal with the acute needs of these pediatric inpatients. Clearly, for whatever reason, whether it is lifestyle, or a comfort level choice, our community pediatricians no longer desire to assume responsibility for providing this level of acute inpatient care for their patients at HOCC.

3. **Evolution of HOCC's Outpatient Pediatric Service.** HOCC currently operates an outpatient clinic historically staffed by two pediatricians. In August of 2014, it became clear that our patient panel would only support the activity of one pediatrician and thus, one of the two positions was eliminated.[1] While the patient panel size does not require more than one provider, operating the hospital-based clinic with a single pediatrician does not provide the infrastructure to ensure optimal access to care. See, http://pediatricinc.com/2012/06/21/how-many-patient-should-my-practice-see/. The clinic operates during normal business hours with no evening or weekend hours. Outside of traditional business hours, an outsourced nurse triage system is utilized to address patient care needs should they arise. If patients have medical needs during those after-hours that cannot be handled by the nurse triage line, the patients are directed to the HOCC emergency department for care. Recently, our remaining outpatient pediatrician has

[1] There were only 1200 patients in the HOCC practice.

informed us that she will leave her HOCC position in the next few months and will soon go into private practice in the New Britain community.[2]

Given the undeniable challenges associated with continuation of this outpatient pediatric program, the lack of coverage and complementary and specialized services, HOCC has determined that the best thing to do for this patient population is to transfer these patients to pediatric providers who can provide a broader range of services and hours. Accordingly, HOCC has agreed to support the Community Health Center (New Britain location) to hire an additional pediatric care provider who will be dedicated to the transition and care of these patients should OHCA approve this Application. As is evident from its web site, Community Health Center has multiple locations not only in New Britain, but also in surrounding towns that offer all of the primary care services that a child may need, including but not limited to behavioral health, comprehensive dental services, nutritional counseling services, school-based clinics and sick and urgent care 24/7, 365 days per year. http://www.chc1.com/. More specifically, HOCC has agreed to fund the salary and benefit expenses of a pediatrician or pediatric nurse practitioner. See Exhibit 5 attached hereto at page 0089 of the Application. In addition, and as mentioned previously in our Application, HOCC has solicited support from HOCC's community pediatricians who have agreed to welcome patients from HOCC's outpatient program into their practices. See Exhibit 5 attached hereto at pages 0080 to 0086 of the Application. Our departing HOCC outpatient clinic pediatrician also anticipates that many of her patients will be joining her at her new practice in New Britain.

[2] This pediatrician had communicated her intent to transition many of her current hospital outpatients to her private practice with Grove Hill Medical Centers.

4. **OHCA Specific Questions Regarding HOCC's Proposal.** The following sets forth HOCC's responses to OHCA specific questions:

a. Describe how the proposal will improve access to care for pediatric inpatients and clinic outpatients that have been or that are currently being treated by the Hospital.

HOCC believes that its pediatric outpatients will be better served if they are cared for by other community providers who can offer enhanced after-hours coverage so that when there are after-hours needs, these families do not have to resort to the emergency department to be seen. In addition, to the extent that HOCC pediatric patients choose Community Health Center as their provider of choice, there will be a more holistic approach to the care and treatment for these children since Community Health Center offers a broader complement of services.

With respect to inpatient care, HOCC does not have the specialized services that more acutely ill children would benefit from when receiving inpatient care. CCMC has indicated its support to receive these children. See page 0087 of the Application. Once these children are discharged from CCMC, they will be referred back to their community providers for continuity of care. Of course, if these children require specialty services, they will be referred to CCMC affiliated specialists to the extent those specialists are unavailable in the child's community.

b. Discuss the quality enhancements to be derived by pediatric patients when they have been transitioned to the earmarked inpatient, community-based and primary care programs that will continue to provide health care services to these individuals.

As stated in my earlier testimony, HOCC pediatric patients transitioned to other community providers will receive more coordinated and continuous care than they are currently receiving from the HOCC outpatient program given HOCC's limited hours of

coverage by a single pediatrician. It is preferable for children to be seen in their providers' office whenever possible without having to resort to visiting the emergency department (unless an emergent condition exists). In addition, the children who will be transitioned to Community Health Center will have greater access to a wider range of primary care services than HOCC currently offers (e.g., dentistry, behavioral health, nutritional counseling). With respect to inpatient services, HOCC believes that children who are acutely ill and needing inpatient hospitalization will be better served in a children's specialty hospital with the specialized competencies that those children need and deserve.

c. In a scenario the Hospital offered in its completeness response, pediatric patients requiring inpatient care would be triaged and stabilized in the Emergency Department ("ED") before being transported to the Connecticut Children's Medical Center for continuing care. Explain further how such an event would not generate an ED charge on the part of Hospital.

HOCC believes that there will likely be an emergency department charge for the patients described in OHCA's question. However, since these patients will be transitioned to community providers that will provide 24/7, 365 days of coverage, it is less likely that these patients will be brought to the HOCC emergency department for non-emergent needs versus being seen by their community provider in the first instance. Should their community providers feel their patients need inpatient admission, the community providers are more likely to send the child directly to CCMC's emergency department, or have the child admitted directly to a CCMC inpatient unit.

d. Discuss the treatment/protocol ramifications of pediatric patients presenting to the Hospital's ED after hours after the proposed terminations have occurred.

The treatment protocol for children presenting to the HOCC emergency department after hours will remain unchanged. If the HOCC emergency department receives a child in its emergency department, it will treat the child and refer the child back to their community

provider. If the child needs inpatient care, the child will be stabilized and transferred to CCMC or another appropriate pediatric inpatient facility of the patient's choice.

e. Describe the affect the proposal will have on the Hospital's continuing pediatric surgical program?

HOCC does not have a specific pediatric surgical program. To the extent that children age thirteen (13) and over require a basic surgical procedure (e.g., orthopedic or uncomplicated appendectomy) and the attending surgeon desires to admit their patient to HOCC as an inpatient, the child would be admitted to a regular adult floor. Therefore, that practice of admitting children without comorbidities and being treated for routine surgeries will remain unchanged.

HOCC understands that every community hospital is not always best suited to provide every service. We have certainly learned that to be the case with other CON submissions made by the Hospital. As the needs of our patients have shifted over time, we are clearly at a point in time wherein continuation of these services is neither in the best interests of the children in our community or the utilization of HOCC's limited resources.

Thank you for your time and attention today and I adopt this pre-filed testimony as my own.

Annmarie Golioto

Annmarie Golioto, M.D., Chief of Pediatrics
The Hospital of Central Connecticut
11/24/15

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman, Esq.
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 24, 2015

VIA HAND DELIVERY

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: **IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS**
DOCKET NO: 15-32023-CON

Dear Ms. Martone:

Enclosed please find the Notice of Appearance form regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Jwf/tja
Enclosure
4431393v1

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE HOSPITAL OF	**:**	**DOCKET NO. 15-32023-CON**
CENTRAL CONNECTICUT'S PROPOSAL	**:**	
TO TERMINATE ITS INPATIENT AND	**:**	
OUTPATIENT PEDIATRIC PROGRAMS	**:**	**November 25, 2015**

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of the Applicant in the above-referenced matter.

Respectfully Submitted,

The Hospital of Central Connecticut

By: _____

Joan W. Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Its Attorney

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman, Esq.
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 24, 2015

VIA HAND DELIVERY

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: **IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS**
DOCKET NO: 15-32023-CON

Dear Ms. Martone:

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Sincerely yours,

Joan W. Feldman

Jwf/tja
Enclosure
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE HOSPITAL OF	**:**	**DOCKET NO. 15-32023-CON**
CENTRAL CONNECTICUT'S PROPOSAL	**:**	
TO TERMINATE ITS INPATIENT AND	**:**	
OUTPATIENT PEDIATRIC PROGRAMS	**:**	**November 25, 2015**

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of the Applicant in the above-referenced matter.

Respectfully Submitted,

The Hospital of Central Connecticut

By: _____

Jean W. Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Its Attorney

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman, Esq.
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 24, 2015

VIA HAND DELIVERY

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: **IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS**
DOCKET NO: 15-32023-CON

Dear Ms. Martone:

Enclosed please find an original and five copies of our Pre-Filed Testimony of Annemarie Golioto, M.D., on behalf of the Applicant regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Jwf/tja
Enclosure
4431393v1

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE	**:**	**DOCKET NO. 13-31851-CON**
ESTABLISHMENT OF AN ORTHOPEDIC	**:**	
AMBULATORY SURGERY CENTER ON	**:**	
THE HARTFORD HOSPITAL CAMPUS	**:**	**DECEMBER 2, 2015**

PRE-FILED TESTIMONY OF ANNMARIE GOLIOTO, M.D., CHIEF OF PEDIATRICS, THE HOSPITAL OF CENTRAL CONNECTICUT

Accompanying this cover sheet is the pre-filed testimony of Annemarie Golioto, M.D. on behalf of the Applicant in the above-captioned application.

Respectfully Submitted,

The Hospital of Central Connecticut

By: _____

Joan W. Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Its Attorney

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS	:	**DOCKET NO. 15-32023-CON**
	:	**December 02, 2015**

PRE-FILED TESTIMONY OF ANNMARIE GOLIOTO, M.D., CHIEF OF PEDIATRICS, THE HOSPITAL OF CENTRAL CONNECTICUT

Good evening, staff of the Office of Health Care Access ("OHCA"). My name is Annmarie Golioto, M.D., and I am an Attending Neonatologist, Director of Nurseries, and Chief of Pediatrics at The Hospital of Central Connecticut ("HOCC" or "Hospital"). I am grateful to have this opportunity to personally speak with you today and convey my reasons for recommending to OHCA that it approve the above-referenced application (the "Application") to terminate HOCC's inpatient and outpatient pediatric programs (the "Programs").

As I have been caring for children for almost twenty (20) years, it is only natural that I feel a great deal of sadness that I am before you today with this proposal. I came to HOCC in 2013 as the Medical Director of the HOCC Nurseries and I have both witnessed and I have been informed by my colleagues of HOCC's efforts to manage and sustain these very Programs. Nevertheless, it has become quite evident to me that the continued viability and sustainability of these Programs is no longer in the best interests of the HOCC community. It is my hope that with my pre-filed testimony that I will be able to clearly articulate all the reasons why this Application should be approved by OHCA.

1. **Evolution of Inpatient Pediatric Care in the Community.** As we stated in greater detail in the Application, medical advances in the treatment of children, along

with improved management of children's health care needs on an outpatient basis, has had a positive and significant impact on the number of children needing inpatient hospital services. See Exhibit 3 at pages 0045 to 0069 of the Application. This is a very good development of course, but the collateral effect has been a significant reduction in the number of low complexity inpatient admissions, which are the type of inpatient pediatric cases cared for at HOCC. Moreover and as also stated in the Application, the children that do in fact require inpatient services are generally more acutely ill with chronic medical conditions that typically involve multiple comorbidities. See pages 0012 to 0014 of the Application. These more acutely ill children benefit from the full range and complement of specialized services offered by a specialty children's hospital, but not typically offered at a community hospital like HOCC. For example, in a children's specialty hospital, pediatric subspecialty physicians are available to address the special medical complexities of children, along with all of the ancillary services normally associated with the delivery of care to children such as, specialized pediatric testing modalities, pediatric nutritionists and pharmacists, physical therapy, occupational therapy, speech therapy, behavioral health, and child life services, to name a few. Therefore, it is my professional opinion, that children who require inpatient care, (typically children that are more acutely ill), need the expertise and specialized range and complement of ancillary services that a specialty children's hospital can offer.

2. **Efforts Made by HOCC to Sustain its Inpatient Pediatric Program.**

To date, and as stated in the Application, HOCC has been very committed to sustaining its pediatric inpatient service. As children requiring inpatient admission have more complex medical needs, inpatient management has become in many ways its own

specialized service as opposed to the historically common model of community pediatricians providing the oversight and management of the inpatient care provided to their patients. As HOCC's inpatient volumes began to decline, HOCC looked for alternative ways to maintain, and grow its inpatient pediatric service. Thus, in 2012, HOCC decided to hire two pediatric hospitalists for the purpose of providing full-time coverage to the pediatric patients who were requiring inpatient care. With this hospitalist service, community pediatricians had the option of referring patients needing inpatient care to the hospitalist-run pediatric service at HOCC, admitting their patient to the HOCC inpatient service under their own care, or referring their patient directly to Connecticut Children's Medical Center ("CCMC"). It has been our experience that community pediatricians chose to either admit to the hospitalist-run service or transfer their patient directly to CCMC depending on the complexity of the patient.

Unfortunately, the benefits of providing the hospitalist coverage did not yield an increase in inpatient admissions to HOCC that would be necessary to sustain the service, and the HOCC inpatient service remained underutilized, leaving the pediatric hospitalists idle. As a consequence, both of the pediatric hospitalists, sceing the proverbial writing on the wall, left the community to secure more challenging positions. Without the demand or volume to justify the program, the pediatric hospitalist program was eliminated by HOCC in 2014. Since that time, HOCC affiliated community pediatricians (with admitting privileges) continue to have the ability to admit and manage their patients on HOCC's pediatric unit should they so choose.

HOCC continues to maintain pediatric nursing coverage in the event that community pediatricians decide to admit their patients, but there has, in fact, been little to

no demand for such nursing services. Given the infrequency of use of these pediatric inpatient services, it is my opinion that continuation of this pediatric inpatient service is not in the best interest of the community we serve. Such a low volume service cannot adequately maintain the nursing and medical competencies that the patients deserve. More specifically, it is my belief that should a child from our community require pediatric inpatient services, it is in their best interest to receive their care from a pediatric specialty hospital, one that is fully staffed with clinicians who have the competencies to deal with the acute needs of these pediatric inpatients. Clearly, for whatever reason, whether it is lifestyle, or a comfort level choice, our community pediatricians no longer desire to assume responsibility for providing this level of acute inpatient care for their patients at HOCC.

3. **Evolution of HOCC's Outpatient Pediatric Service.** HOCC currently operates an outpatient clinic historically staffed by two pediatricians. In August of 2014, it became clear that our patient panel would only support the activity of one pediatrician and thus, one of the two positions was eliminated.[1] While the patient panel size does not require more than one provider, operating the hospital-based clinic with a single pediatrician does not provide the infrastructure to ensure optimal access to care. See, http://pediatricinc.com/2012/06/21/how-many-patient-should-my-practice-see/. The clinic operates during normal business hours with no evening or weekend hours. Outside of traditional business hours, an outsourced nurse triage system is utilized to address patient care needs should they arise. If patients have medical needs during those after-hours that cannot be handled by the nurse triage line, the patients are directed to the HOCC emergency department for care. Recently, our remaining outpatient pediatrician has

[1] There were only 1200 patients in the HOCC practice.

informed us that she will leave her HOCC position in the next few months and will soon go into private practice in the New Britain community.[2]

Given the undeniable challenges associated with continuation of this outpatient pediatric program, the lack of coverage and complementary and specialized services, HOCC has determined that the best thing to do for this patient population is to transfer these patients to pediatric providers who can provide a broader range of services and hours. Accordingly, HOCC has agreed to support the Community Health Center (New Britain location) to hire an additional pediatric care provider who will be dedicated to the transition and care of these patients should OHCA approve this Application. As is evident from its web site, Community Health Center has multiple locations not only in New Britain, but also in surrounding towns that offer all of the primary care services that a child may need, including but not limited to behavioral health, comprehensive dental services, nutritional counseling services, school-based clinics and sick and urgent care 24/7, 365 days per year. http://www.chc1.com/. More specifically, HOCC has agreed to fund the salary and benefit expenses of a pediatrician or pediatric nurse practitioner. See Exhibit 5 attached hereto at page 0089 of the Application. In addition, and as mentioned previously in our Application, HOCC has solicited support from HOCC's community pediatricians who have agreed to welcome patients from HOCC's outpatient program into their practices. See Exhibit 5 attached hereto at pages 0080 to 0086 of the Application. Our departing HOCC outpatient clinic pediatrician also anticipates that many of her patients will be joining her at her new practice in New Britain.

[2] This pediatrician had communicated her intent to transition many of her current hospital outpatients to her private practice with Grove Hill Medical Centers.

4. **OHCA Specific Questions Regarding HOCC's Proposal.** The following sets forth HOCC's responses to OHCA specific questions:

a. Describe how the proposal will improve access to care for pediatric inpatients and clinic outpatients that have been or that are currently being treated by the Hospital.

HOCC believes that its pediatric outpatients will be better served if they are cared for by other community providers who can offer enhanced after-hours coverage so that when there are after-hours needs, these families do not have to resort to the emergency department to be seen. In addition, to the extent that HOCC pediatric patients choose Community Health Center as their provider of choice, there will be a more holistic approach to the care and treatment for these children since Community Health Center offers a broader complement of services.

With respect to inpatient care, HOCC does not have the specialized services that more acutely ill children would benefit from when receiving inpatient care. CCMC has indicated its support to receive these children. See page 0087 of the Application. Once these children are discharged from CCMC, they will be referred back to their community providers for continuity of care. Of course, if these children require specialty services, they will be referred to CCMC affiliated specialists to the extent those specialists are unavailable in the child's community.

b. Discuss the quality enhancements to be derived by pediatric patients when they have been transitioned to the earmarked inpatient, community-based and primary care programs that will continue to provide health care services to these individuals.

As stated in my earlier testimony, HOCC pediatric patients transitioned to other community providers will receive more coordinated and continuous care than they are currently receiving from the HOCC outpatient program given HOCC's limited hours of

coverage by a single pediatrician. It is preferable for children to be seen in their providers' office whenever possible without having to resort to visiting the emergency department (unless an emergent condition exists). In addition, the children who will be transitioned to Community Health Center will have greater access to a wider range of primary care services than HOCC currently offers (e.g., dentistry, behavioral health, nutritional counseling). With respect to inpatient services, HOCC believes that children who are acutely ill and needing inpatient hospitalization will be better served in a children's specialty hospital with the specialized competencies that those children need and deserve.

c. In a scenario the Hospital offered in its completeness response, pediatric patients requiring inpatient care would be triaged and stabilized in the Emergency Department ("ED") before being transported to the Connecticut Children's Medical Center for continuing care. Explain further how such an event would not generate an ED charge on the part of Hospital.

HOCC believes that there will likely be an emergency department charge for the patients described in OHCA's question. However, since these patients will be transitioned to community providers that will provide 24/7, 365 days of coverage, it is less likely that these patients will be brought to the HOCC emergency department for non-emergent needs versus being seen by their community provider in the first instance. Should their community providers feel their patients need inpatient admission, the community providers are more likely to send the child directly to CCMC's emergency department, or have the child admitted directly to a CCMC inpatient unit.

d. Discuss the treatment/protocol ramifications of pediatric patients presenting to the Hospital's ED after hours after the proposed terminations have occurred.

The treatment protocol for children presenting to the HOCC emergency department after hours will remain unchanged. If the HOCC emergency department receives a child in its emergency department, it will treat the child and refer the child back to their community

provider. If the child needs inpatient care, the child will be stabilized and transferred to CCMC or another appropriate pediatric inpatient facility of the patient's choice.

e. *Describe the affect the proposal will have on the Hospital's continuing pediatric surgical program?*

HOCC does not have a specific pediatric surgical program. To the extent that children age thirteen (13) and over require a basic surgical procedure (e.g., orthopedic or uncomplicated appendectomy) and the attending surgeon desires to admit their patient to HOCC as an inpatient, the child would be admitted to a regular adult floor. Therefore, that practice of admitting children without comorbidities and being treated for routine surgeries will remain unchanged.

HOCC understands that every community hospital is not always best suited to provide every service. We have certainly learned that to be the case with other CON submissions made by the Hospital. As the needs of our patients have shifted over time, we are clearly at a point in time wherein continuation of these services is neither in the best interests of the children in our community or the utilization of HOCC's limited resources.

Thank you for your time and attention today and I adopt this pre-filed testimony as my own.

Annmarie Golioto

Annmarie Golioto, M.D., Chief of Pediatrics
The Hospital of Central Connecticut
11/24/15

* * * COMMUNICATION RESULT REPORT (DEC. 1. 2015 2:43PM) * * *

FAX HEADER:

TRANSMITTED/STORED : DEC. 1. 2015 2:41PM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
398 MEMORY TX		98609729025	OK	4/4

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: BARBARA DURDY

FAX: 860 972-9025

AGENCY: HARTFORD HEALTHCARE

FROM: OHCA

DATE: 12/1/15 **Time:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments:
Information regarding the hearing scheduled for December 2, 2015
For the Hospital of Central Connecticut

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

HEARING

Docket Number: 15-32023-CON

Hospital of Central Connecticut

The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services

December 2, 2015 at 5:00 p.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony

III. OHCA's Questions-Applicant

IV. Public Comment

V. Closing Remarks

VI. Public Hearing Adjourned

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Hospital of Central Connecticut**

DOCKET NUMBER: **15-32023-CON**

PUBLIC HEARING: **December 2, 2015 at 5:00 p.m.**

PLACE: **New Britain High School**
Lecture Hall
110 Mill Street
New Britain, CT

EXHIBIT	DESCRIPTION
A	Letter from the Hospital of Central Connecticut (Applicant) to OHCA dated August 28, 2015, with Certificate of Need (CON) application for the Termination of Inpatient and Outpatient Pediatric Services under Docket Number 15-32023, received by OHCA on August 28, 2015. (122 Pages)
B	OHCA's letter to the Applicant dated September 18, 2015, requesting additional information and/or clarification in the matter of the CON application under Docket Number 15-32023. (6 Pages)
C	Applicant's responses to OHCA's letter of September 18, 2015, dated October 14, 2015, in the matter of the CON application under Docket Number 15-32023, received by OHCA on October 14, 2015. (21 Pages)
D	OHCA's letter to the Applicant dated August 13, 2015 deeming the application complete in the matter of the CON application filed under Docket Number 15-32023. (2 pages)
E	OHCA's request for legal notification in the *Herald* of New Britain and OHCA's Notice to the Applicant of the public hearing scheduled for December 2, 2015, in the matter of the CON application under Docket Number 15-32023, each document dated November 10, 2015. (4 pages)
F	Designation letter dated November 10, 2015, of the Hearing Officer in the matter of the CON application under Docket Number 15-32023. (1 page)

G	OHCA's letter to the Applicant dated November 13, 2015, requesting prefile testimony and response to issues in the matter of the CON application under Docket Number 15-32023. (5 pages)
H	Letter from the Applicant to OHCA dated November 24, 2015 noticing the appearance of Shipman & Goodwin LLP and enclosing prefile testimony in the matter of the CON application under Docket Number 15-32023, received by OHCA on November 24, 2015. (13 pages)

New Britain
EMERGENCY MEDICAL SERVICES, INC.

"Helping People - Saving Lives - Caring for the Community" Since 1977

November 23, 2015

Kimberly Martone, Director of Operations
Office of Health Care Access
Department of Public Health
410 Capital Ave
MS# 13HCA
P.O. Box 340308
Hartford, CT 06314-0308

RE: HOCC Application to terminate inpatient/outpatient pediatric services.

Dear Ms. Martone:

As the CEO of New Britain Emergency Medical Services, Inc. the City of New Britain's 9-1-1 EMS lead response agency, I am writing to express my support for the proposal by The Hospital of Central Connecticut (HOCC) to terminate its inpatient and outpatient pediatric service programs.

We have a close collaborative working relationship with HOCC and its Emergency Department. Should the proposal be approved by the Office of Health Care Access, we have the capacity and capability to transport any pediatric patients from our New Britain service area to Connecticut Children's Medical Center or an appropriate alternative of the patient's choice as deemed necessary and appropriate.

Sincerely,

Bruce Baxter, CEO

225 Arch Street • P.O. Box 2018 • New Britain, CT 06050-2018 • (860) 225-8787 • Fax (860) 225-0139 • office@nbems.org

CITY OF NEW BRITAIN

The Honorable
Erin E. Stewart
Mayor

Kimberly Martone
Office of Health Care Access
410 Capitol Ave.
MS #13HCA
Hartford, CT 06134-0308

December 2, 2015

Re: The Hospital of Central Connecticut's Proposal to Terminate Inpatient and Outpatient Pediatric Services Docket No. 15--32023-CON

Dear Ms. Martone:

I am writing as Mayor of the City of New Britain to convey my full support of The Hospital of Central Connecticut's proposal to discontinue the provision of inpatient and outpatient pediatric services. As you know, hospitals in Connecticut are facing significant budgetary challenges and thus, must make difficult decisions in order to utilize their resources in the most cost-effective and responsive manner.

The City of New Britain is fortunate to have a wealth of high quality providers of pediatric services. Given the Hospital's plan to transition its patients to Community Health Center and other community providers, I am in full support of the Hospital's decision to discontinue services that are underutilized and duplicative. If we are going to continue to have The Hospital of Central Connecticut remain a vibrant hospital and a major contributor of our City's economy, we cannot create obstacles that will inhibit their ability to be responsive to the marketplace.

Accordingly, I respectfully request that you approve the above-referenced application and I trust that the Office of Health Care Access will do what is in the best interests of the community.

Sincerely,

Erin E. Stewart
Mayor

27 West Main Street, New Britain, CT 06051
Tel: 860.826.3303 Fax: 860.826.3308
www.newbritainct.gov
mayor@newbritainct.gov

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Hospital of Central Connecticut

DN: 15-32023-CON

Hearing Date: December 2, 2015

Time: 5:00 p.m.

Proposal: The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services

Applicant Late File #	Description
1	Listing of Asthma Programs itemized by the following categories: Provided by, funded by and/or supported by the Hospital of Central Connecticut.
2	A. Historical Financials for the Hospital's **Inpatient Pediatric Service** for FYs 2013 through 2015. B. Historical Financials for the Hospital's **Outpatient Pediatric Clinic Service** for FYs 2013 through 2015.
3	Revised Financial Projections taking into consideration the changing revenue/expense considerations discussed during the public hearing. An explanation of the changes made in developing the revised financial projections should accompany the projections.
4	

OHCA Exhibit #	Description
1	The Hospital of Central Connecticut's 2015 Community Health Needs Assessment Summary Report, dated June 2015.
2	
3	
4	
5	

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

December 2, 2015
5:00 p.m.

Docket Number: 15-32023-CON
Hospital of Central Connecticut
The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services

PRINT NAME	Phone	Fax	Representing Organization
Barbara Dardy	972-4231		HHC
Joan Feldman	860 251-5704		HHC
Annmarie Golioto	2036055420		HOCC
David Buono	860 224 5675		HOCC
Carolyn Frechet	860 224-5194		HOCC

Hospital of Central Connecticut
DN: 15-32023-CON

PRINT NAME	Phone	Fax	Representing Organization
Nancy Kroeber	860-224-5255		HOCC
Joseph Vaccarelli	203-879-5998		HOCC
Lucille Janatka	203 537-0193		HOCC
Cathy Stevens	2038590245		HOCC
Karen Goyette	860 462 0167		HHC
Kim Harris	860 [illegible] 963-4187		HHC
Chris Heneghan	860-239-7313		HHC
Eveline Schaffer	860 8051510		HHC.
Corey Russo	2035372042		HOCC.

PUBLIC HEARING
PUBLIC OFFICIAL
SIGN UP SHEET

December 2, 2015
5:00 p.m.

Docket Number: 15-32023-CON
Hospital of Central Connecticut
The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services

PRINT NAME	Phone	Fax	Representing Organization
Daniel Davis	(860) 922-9252		city of New Britain

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

December 2, 2015
5:00 p.m.

Docket Number: 15-32023-CON
Hospital of Central Connecticut
The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services

PRINT NAME	Representing Self or Organization
Melanie Gedraitis	self
Yvette Highsmith Franco	Community Health Center, Inc.
~~ANAND SEKARAN MD~~	~~CONNECTICUT CHILDREN'S~~
Ramona Anderson	self

OHCA Exhibit 1

Summary Report

2015 Community Health Needs Assessment

The Hospital of Central Connecticut Service Area

Prepared for:
The Hospital of Central Connecticut

By:
Professional Research Consultants, Inc.
11326 P Street Omaha, NE 68136-2316
www.PRCCustomResearch.com

2014-2613-02

Professional Research Consultants, Inc.

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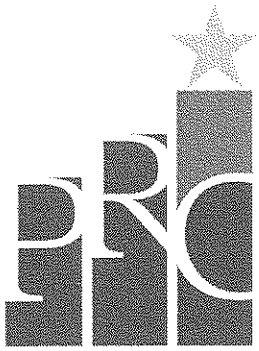
Introduction



Professional Research Consultants, Inc.

About This Assessment

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Hospital of Central Connecticut (HOCC) Service Area. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Hartford HealthCare by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

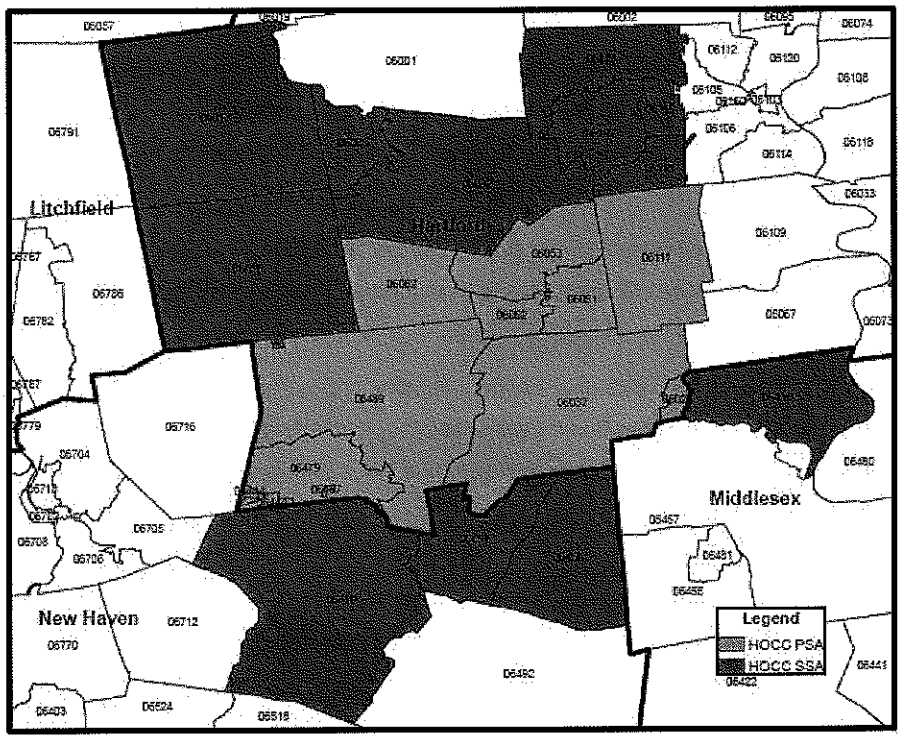
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Hartford HealthCare and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Hospital of Central Connecticut Service Area" in this report, or "HOCC") is defined by 23 residential ZIP Codes segmented into two sub-areas (the Primary Service Area, or PSA, and the Secondary Service Area, or SSA) in Connecticut. This area definition is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 798 individuals age 18 and older in the Hospital of Central Connecticut Service Area. Because this study is part of a larger effort involving multiple regions and hospital service areas, the surveys were distributed among various strata. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Hospital of Central Connecticut Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 798 respondents is ±3.5% at the 95 percent level of confidence.

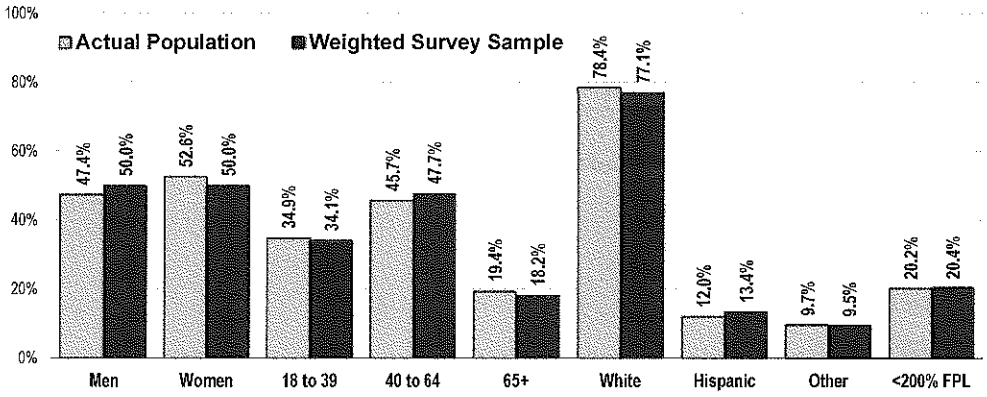
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random

sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Hospital of Central Connecticut Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(HOCC Service Area, 2015)



Sources:
- Census 2010, Summary File 3 (SF 3). US Census Bureau.
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2014 guidelines place the poverty threshold for a family of four at $23,850 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Hartford HealthCare; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 47 community stakeholders in the HOCC Service Area took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	**Number Invited**	**Number Participating**
Community/Business Leader	41	11
Other Health (Non-Physician)	19	16
Physician	10	3
Public Health Expert	9	5
Social Services Representative	27	12

Final participation included representatives of the organizations outlined below.

- Capital Community College
- Central Connecticut Health District
- Charter Oak Health Center
- Chrysalis Center, Inc.
- Community Health Services, Inc.
- Connecticut Association of Directors of Health
- Connecticut Children's Medical Center
- Connecticut Department of Public Health
- Connecticut State Colleges and Universities
- Connecticut State Medical Society
- FaithCare, Inc.
- Farmington Valley Health District
- Hartford Behavioral Health
- Hartford Food System, Inc.
- Hartford Foundation for Public Giving
- Hartford Gay and Lesbian Health Collective
- Hartford Hospital
- Hartford Public Schools
- Hispanic Health Council
- Intercommunity, Inc.
- LCS
- Legal Assistance Resource Center
- Malta House of Care Foundation
- Manchester Community College
- Manchester Health Department

- Manchester Public Schools
- Mental Health Association of Connecticut, Inc.
- Northern Connecticut Black Nurses Association
- South Windsor Human Services
- United Way
- Urban Alliance, Inc.
- West Hartford-Bloomfield Health District
- YWCA

Through this process, input was gathered from several individuals whose organizations work with **low-income, minority populations** (including African-Americans, American Indians, Asians, Bosnians, Eastern Europeans, ex-offenders, Hispanics, lesbian/gay/bisexual/transgender individuals, low-income residents, Middle Eastern peoples, mixed race individuals, multiple religion families, non-English speaking persons, refugee immigrants, undocumented immigrants, uninsured/underinsured persons, West Indian residents, women), or other **medically underserved populations** (including those with access and functional needs, African-Americans, Asians, children, deaf/hard of hearing persons, disabled individuals, the elderly, Hispanics, homeless persons, immigrants, lesbian/gays/bisexual/transgender individuals, low-income residents, Medicaid/Medicare recipients, mentally ill persons, Native Americans, non-English speaking persons, people in rural areas, racial/ethnic minorities, single parents, those with substance abuse issues, undocumented immigrants, uninsured/ underinsured residents, veterans, young adults).

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Hospital of Central Connecticut Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics

- Community Commons
- Connecticut Department of Public Health
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that town-specific secondary data were sought and included where available; the remainder of secondary data indicators reflect county-level data for Hartford County.

Benchmark Data

State Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2013 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention

experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

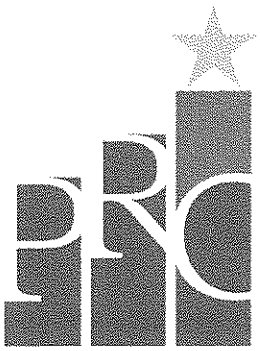
In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H	See Report Page(s)
Part V Section B Line 1a *A definition of the community served by the hospital facility*	5
Part V Section B Line 1b *Demographics of the community*	31
Part V Section B Line 1c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	160
Part V Section B Line 1d *How data was obtained*	5
Part V Section B Line 1f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 1g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	15
Part V Section B Line 1h *The process for consulting with persons representing the community's interests*	7
Part V Section B Line 1i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	11

Summary of Findings



Professional Research Consultants, Inc.

Significant Health Needs of the Community

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	

Cancer	• Cancer Deaths
	  ○ Including Prostate Cancer, Colorectal Cancer Deaths
	  ○ Cancer is the #2 leading cause of death
	• Cancer Incidence
	  ○ Including Prostate Cancer, Female Breast Cancer
	• Colorectal Cancer Screening (PSA)

Chronic Kidney Disease	• Kidney Disease Deaths
Dementia, Including Alzheimer's Disease	• Alzheimer's Disease Deaths
Diabetes	• Diabetes Prevalence • Prevalence of Borderline/Pre-Diabetes • *Diabetes ranked #3 as a "major problem" in the Online Key Informant Survey*
Heart Disease & Stroke	• Heart disease is the #1 leading cause of death; stroke is the #3 leading cause • High Blood Pressure Prevalence
HIV/AIDS	• HIV/AIDS Deaths • HIV Prevalence
Infant Health & Family Planning	• Prenatal Care • Low-Weight Births • Infant Mortality • Teen Births
Injury & Violence	• Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths • Violent Crime Rate • *Injury & Violence ranked #5 as a "major problem" in the Online Key Informant Survey*
Mental Health	• Suicide Deaths • *Mental Health ranked #1 as a "major problem" in the Online Key Informant Survey*
Nutrition, Physical Activity & Weight	• Low Food Access • Overweight & Obesity [Adults] • Leisure-Time Physical Activity (PSA) • Moderate Physical Activity • Access to Recreation/Fitness Facilities • *Nutrition, Physical Activity & Weight ranked #2 as a "major problem" in the Online Key Informant Survey*

Areas of Opportunity (continued)	
Potentially Disabling Conditions	• Sciatica/Back Pain Prevalence
Respiratory Diseases	• Asthma Prevalence [Children] • Pneumonia/Influenza Deaths • Pneumonia Vaccination Among Seniors (SSA)
Sexually Transmitted Diseases	• Gonorrhea Incidence • Chlamydia Incidence
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Alcohol Use • Seeking Help for Substance Abuse Issues • *Substance Abuse ranked #4 as a "major problem" in the Online Key Informant Survey*

Prioritization of Health Needs

On June 10, 2015, The Hospital of Central Connecticut hosted a meeting of both internal stakeholders and representatives of community organizations to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research.

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Subsequently, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs, a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Nutrition, Physical Activity & Weight
2. Mental Health
3. Heart Disease & Stroke
4. Diabetes
5. Cancer
6. Substance Abuse
7. Respiratory Diseases
8. Infant Health & Family Planning
9. Dementias, Including Alzheimer's Disease
10. Injury & Violence
11. Sexually Transmitted Diseases
12. Chronic Kidney Disease
13. HIV/AIDS
14. Potentially Disabling Conditions

While the hospital will likely not implement strategies for all of these health issues, the results of this prioritization exercise will be used to inform the development of HOCC's Implementation Strategy to address the top health needs of the community in the coming years.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Hospital of Central Connecticut Service Area. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Data Summary Tables

In the following charts, the Hospital of Central Connecticut Service Area results are shown in the larger, blue column.

The columns to the right of the service area column provide comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether the Hospital of Central Connecticut Service Area compares favorably (☼), unfavorably (🌧), or comparably (⛅) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Overall Health	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	16.1	11.3	13.3	13.3	15.3	
% Activity Limitations	20.4	20.1	20.2	17.5	21.5	
	Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			☼ better	⛅ similar	🌧 worse

Access to Health Services	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	4.0	6.4	5.5	12.3	15.1	0.0
% [Insured] Went Without Coverage in Past Year	5.0	3.6	4.2		8.1	
% Difficulty Accessing Healthcare in Past Year (Composite)	34.5	34.3	34.4		39.9	
% Inconvenient Hrs Prevented Dr Visit in Past Year	15.6	16.0	15.8		15.4	

% Cost Prevented Getting Prescription in Past Year	10.9	13.2	12.2	15.8	
% Cost Prevented Physician Visit in Past Year	8.5	7.9	8.2	18.2	
% Difficulty Getting Appointment in Past Year	13.1	13.1	13.1	17.0	
% Difficulty Finding Physician in Past Year	8.5	7.8	8.1	11.0	
% Transportation Hindered Dr Visit in Past Year	5.0	7.5	6.5	9.4	
% Skipped Prescription Doses to Save Costs	11.5	10.0	10.6	15.3	
% Difficulty Getting Child's Healthcare in Past Year	0.4	2.1	1.3	6.0	
Primary Care Doctors per 100,000			91.4	84.0	74.5
% [Age 18+] Have a Specific Source of Ongoing Care	76.8	75.7	76.1	76.3	95.0
% [Age 18-64] Have a Specific Source of Ongoing Care	78.7	74.8	76.4	75.6	89.4
% [Age 65+] Have a Specific Source of Ongoing Care	69.1	79.1	74.7	80.0	100.0
% Have Had Routine Checkup in Past Year	75.1	75.3	75.2	71.8	65.0
% Child Has Had Checkup in Past Year	97.0	97.5	97.3	84.1	
% Two or More ER Visits in Past Year	12.0	6.7	8.9	8.9	
% Rate Local Healthcare "Fair/Poor"	10.0	9.3	9.5	16.5	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Arthritis, Osteoporosis & Chronic Back Conditions	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	42.1	35.0	37.8		37.3	
% [50+] Osteoporosis	10.6	9.0	9.6		13.5	5.3
% Sciatica/Chronic Back Pain	21.9	27.0	24.9		18.4	
	Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse

Cancer	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)			155.0	153.0	166.2	161.4
Lung Cancer (Age-Adjusted Death Rate)			38.3	38.7	44.7	45.5
Prostate Cancer (Age-Adjusted Death Rate)			20.7	18.2	19.8	21.8
Female Breast Cancer (Age-Adjusted Death Rate)			19.4	19.2	21.3	20.7
Colorectal Cancer (Age-Adjusted Death Rate)			12.9	12.1	14.9	14.5
Prostate Cancer Incidence per 100,000			157.0	152.4	142.3	
Female Breast Cancer Incidence per 100,000			133.0	136.6	122.7	
Lung Cancer Incidence per 100,000			64.9	64.8	64.9	
Colorectal Cancer Incidence per 100,000			43.2	42.7	43.3	
Cervical Cancer Incidence per 100,000			5.4	6.2	7.8	

% Skin Cancer	6.0	6.5		6.3	5.8	6.7	
% Cancer (Other Than Skin)	7.6	5.9		6.6	7.5	6.1	
% [Women 50-74] Mammogram in Past 2 Years	83.9	86.3		85.3	81.5	83.6	81.1
% [Women 21-65] Pap Smear in Past 3 Years	91.3	88.9		89.9	80.1	83.9	93.0
% [Age 50-75] Colorectal Cancer Screening	79.1	88.1		84.8		75.1	70.5
	Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.				better	similar	worse

Chronic Kidney Disease	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)			14.7	12.5	13.2	
% Kidney Disease	3.2	2.0	2.5	2.1	3.0	
	Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse

Diabetes	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)			13.9	14.8	21.3	20.5
% Diabetes/High Blood Sugar	12.1	9.8	10.7	8.3	11.7	
% Borderline/Pre-Diabetes	10.5	8.9	9.6		5.1	
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	56.0	59.3	57.9		49.2	
	Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse

Dementias, Including Alzheimer's Disease	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)			17.4	16.5	24.0	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Family Planning	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Births to Teens (Percent)			5.9	5.1	7.8	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Hearing & Other Sensory or Communication Disorders	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% Deafness/Trouble Hearing			9.2		10.3	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Heart Disease & Stroke	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)			156.6	153.4	171.3	156.9
Stroke (Age-Adjusted Death Rate)			27.0	27.9	37.0	34.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	7.3	5.5	6.2		6.1	
% Stroke	2.7	1.2	1.8	2.3	3.9	

	PSA	SSA	HOCC Service Area	vs. CT	vs. US	vs. HP2020
% Blood Pressure Checked in Past 2 Years	95.5	95.8	95.7		91.0	92.6
% Told Have High Blood Pressure (Ever)	36.4	34.3	35.2	31.3	34.1	26.9
% [HBP] Taking Action to Control High Blood Pressure	90.3	87.5	88.6		89.2	
% Cholesterol Checked in Past 5 Years	96.6	96.5	96.5	83.1	86.6	82.1
% Told Have High Cholesterol (Ever)	30.7	34.0	32.7	37.8	29.9	13.5
% [HBC] Taking Action to Control High Blood Cholesterol	87.3	94.8	91.9		81.4	
% 1+ Cardiovascular Risk Factor	85.2	83.3	84.1		82.3	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HIV	PSA	SSA	HOCC Service Area	vs. CT	vs. US	vs. HP2020
HIV/AIDS (Age-Adjusted Death Rate)			2.9	2.0	2.2	3.3
HIV Prevalence per 100,000			434.5	359.7	340.4	
% [Age 18-44] HIV Test in the Past Year	18.3	23.5	21.3		19.3	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Immunization & Infectious Diseases	PSA	SSA	HOCC Service Area	vs. CT	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	66.8	55.4	60.4	63.6	57.5	70.0
% [High-Risk 18-64] Flu Vaccine in Past Year	50.5	51.8	51.2		45.9	70.0

% [Age 65+] Pneumonia Vaccine Ever	77.0	60.1	67.3	67.8	68.4	90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever	30.6	35.9	33.5		41.9	60.0
% Have Completed Hepatitis B Vaccination Series	49.0	52.0	50.8		44.7	
	Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse

Injury & Violence Prevention	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)			37.8	35.8	39.2	36.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)			8.4	7.1	10.7	12.4
% "Always" Wear Seat Belt	89.8	92.1	91.2		84.8	92.0
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	95.6	98.2	96.9		92.2	
% Child [Age 5-17] "Always" Wears Bicycle Helmet	55.9	64.2	60.2		48.7	
Firearm-Related Deaths (Age-Adjusted Death Rate)			5.8	5.5	10.4	9.3
% Firearm in Home	16.8	16.8	16.8		34.7	
% [Homes With Children] Firearm in Home	17.0	16.1	16.5		37.4	
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	4.5	11.1	8.4		16.8	
Homicide (Age-Adjusted Death Rate)			4.1	3.8	5.3	5.5
Violent Crime per 100,000			323.2	280.6	395.5	

% Victim of Violent Crime in Past 5 Years	2.0	4.3	3.4		2.8
% Victim of Domestic Violence (Ever)	12.7	11.1	11.7		15.0

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Maternal, Infant & Child Health	Each Svc Area vs. the Other PSA	SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks vs. CT	vs. US	vs. HP2020
No Prenatal Care in First Trimester (Percent)			14.3	13.0		22.1
Low Birthweight Births (Percent)			8.4	7.8	8.0	7.8
Infant Death Rate			5.7	4.9	6.0	6.0

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Mental Health & Mental Disorders	Each Svc Area vs. the Other PSA	SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks vs. CT	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	12.0	13.0	12.6		11.9	
% Diagnosed Depression	13.1	19.5	16.9		20.4	
% Symptoms of Chronic Depression (2+ Years)	25.6	24.1	24.7		30.4	
Suicide (Age-Adjusted Death Rate)			9.3	9.5	12.5	10.2
% Have Ever Sought Help for Mental Health	22.8	31.7	28.0		23.7	
% [Those With Diagnosed Depression] Seeking Help	81.1	82.9	82.3		76.6	

% Member of HH Sought Help for Mental Health/Past Year	14.9	16.9	16.1		
% Typical Day Is "Extremely/Very" Stressful	10.2	13.8	12.3		11.9
% [Child <18] Child Has "Fair/Poor" Mental Health	11.7	4.8	7.9		
% [Child <18] Couldn't Get Mental Help for Child in Past Yr	0.5	0.9	0.7		

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Nutrition & Weight Status	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	37.5	38.8	38.3		39.5	
% "Very/Somewhat" Difficult to Buy Fresh Produce	19.1	15.5	16.9		24.4	
Population With Low Food Access (Percent)			30.6	29.8	23.6	
% Medical Advice on Nutrition in Past Year	48.6	48.3	48.4		39.2	
% Healthy Weight (BMI 18.5-24.9)	25.6	31.2	28.9	35.6	34.4	33.9
% Overweight (BMI 25+)	73.9	68.1	70.4	62.6	63.1	
% Obese (BMI 30+)	36.0	32.0	33.6	25.0	29.0	30.5
% Medical Advice on Weight in Past Year	30.3	33.4	32.1		23.7	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	37.1	40.5	39.1		39.5	
% Child [Age 5-17] Healthy Weight	54.7	50.5	52.4		56.7	

% Children [Age 5-17] Overweight (85th Percentile)	35.9	34.2	34.9	31.5	
% Children [Age 5-17] Obese (95th Percentile)	16.3	23.7	20.2	14.8	14.5

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Oral Health	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	78.2	80.6	79.6	76.1	65.9	49.0
% Child [Age 2-17] Dental Visit in Past Year	89.5	84.6	86.9		81.5	49.0
% Have Dental Insurance	81.4	79.5	80.2		65.6	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Physical Activity	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% No Leisure-Time Physical Activity	26.9	18.8	22.1	24.9	20.7	32.6
% Meeting Physical Activity Guidelines	46.1	48.2	47.4		50.3	
% Moderate Physical Activity	25.0	25.1	25.1		30.6	
% Vigorous Physical Activity	35.9	36.4	36.2		38.0	
Recreation/Fitness Facilities per 100,000			12.2	13.2	9.4	
% Medical Advice on Physical Activity in Past Year	52.9	51.1	51.9		44.0	

% Child [Age 2-17] Physically Active 1+ Hours per Day	38.5	49.3	44.2	48.6	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Respiratory Diseases	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	HOCC Service Area vs. Benchmarks: vs. US	HOCC Service Area vs. Benchmarks: vs. HP2020
CLRD (Age-Adjusted Death Rate)			30.1	30.9	42.0	
Pneumonia/Influenza (Age-Adjusted Death Rate)			14.2	12.9	15.3	
% COPD (Lung Disease)	7.6	7.8	7.7	5.9	8.6	
% [Adult] Currently Has Asthma	11.2	7.8	9.2	9.8	9.4	
% [Child 0-17] Currently Has Asthma	10.6	14.1	12.6		7.1	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Sexually Transmitted Diseases	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	HOCC Service Area vs. Benchmarks: vs. US	HOCC Service Area vs. Benchmarks: vs. HP2020
Gonorrhea Incidence per 100,000			75.9	57.4	107.5	
Chlamydia Incidence per 100,000			447.2	364.9	456.7	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	5.3	9.7	8.1		11.7	
% [Unmarried 18-64] Using Condoms	32.6	42.5	38.8		33.6	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Substance Abuse	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)			8.5	7.6	9.9	8.2
% Current Drinker	62.5	67.4	65.4	62.6	56.5	
% Excessive Drinker (Heavy or Binge Drinking)	24.2	24.1	24.2		23.2	25.4
% Drinking & Driving in Past Month	4.8	3.5	4.0		5.0	
Drug-Induced Deaths (Age-Adjusted Death Rate)			13.6	13.5	14.1	11.3
% Illicit Drug Use in Past Month	2.9	3.3	3.2		4.0	7.1
% Ever Sought Help for Alcohol or Drug Problem	2.6	2.8	2.7		4.9	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Tobacco Use	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% Current Smoker	12.0	12.2	12.1	15.5	14.9	12.0
% Someone Smokes at Home	10.1	9.8	9.9		12.7	
% [Non-Smokers] Someone Smokes in the Home	5.7	4.8	5.2		6.3	
% [Household With Children] Someone Smokes in the Home	7.2	5.7	6.4		9.7	
% [Smokers] Received Advice to Quit Smoking			81.5		67.8	

% [Smokers] Have Quit Smoking 1+ Days in Past Year			65.8		55.9	80.0
% Smoke Cigars	2.9	5.5	4.5		4.1	0.2
% Use Smokeless Tobacco	1.1	1.3	1.2		4.0	0.3

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

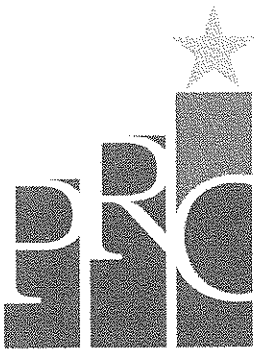
better similar worse

Vision	Each Svc Area vs. the Other: PSA	Each Svc Area vs. the Other: SSA	HOCC Service Area	HOCC Service Area vs. Benchmarks: vs. CT	vs. US	vs. HP2020
% Blindness/Trouble Seeing	8.6	5.8	6.9		8.5	
% Eye Exam in Past 2 Years	64.5	69.9	67.7		56.8	

Note: In the green section, each service area is compared against the other. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Data Charts &
Key Informant Input



Professional Research Consultants, Inc.

Community Characteristics

Population Characteristics

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, density, age, race/ethnicity and language. Keep in mind:

- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.
- Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.
- It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

Population Characteristics

	Hartford County	Connecticut	United States
Total Population	**893,504**	3,572,213	309,138,709
Total Land Area (sq. miles)	**734.90**	4,841.1	3,530,997.60
Population Density	**1,215.81**	737.89	87.55
2000-2010 Population Change	**4.3%**	5.0%	9.7%
Urban Population	**94.6%**	88.0%	80.9%
Age 0-17	**22.7%**	22.7%	23.9%
Age 18-64	**62.6%**	63.0%	62.9%
Age 65+	**14.6%**	14.3%	13.2%
Median Age	**39.9**	40.0	37.2
White Alone	**73.3%**	78.4%	74.2%
Black Alone	**13.1%**	10.0%	12.6%
Some Other Race	**10.9%**	9.1%	10.6%
Multiple Races	**2.7%**	2.5%	2.7%
Hispanic or Latino	**15.4%**	13.4%	16.4%
2000-2010 Hispanic Population Change	**38.2%**	49.6%	42.7%
Linguistically Isolated Population	**5.2%**	4.7%	4.9%

Sources: • Community Commons. Retrieved April 2015 from http://www.chna.org.
Notes: • Data are derived from the US Census Bureau American Community Survey 5-year estimates (2008-2012).

Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

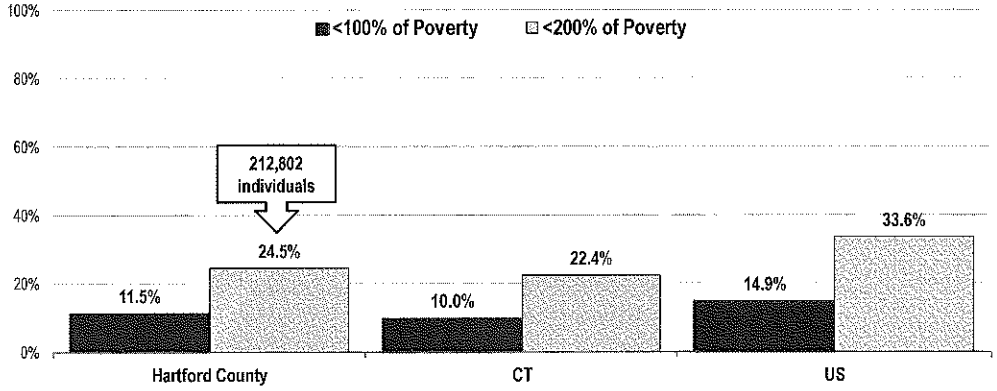
- Healthy People 2020 (www.healthypeople.gov)

Social Determinants	HOCC Service Area	HOCC Service Area vs. Benchmarks	
		vs. CT	vs. US
Linguistically Isolated Population (Percent)	5.2	worse 4.7	worse 4.9
Population in Poverty (Percent)	11.5	worse 10.0	better 14.9
Population Below 200% FPL (Percent)	24.5	worse 22.4	better 33.6
Children Below 200% FPL (Percent)	15.8	worse 13.2	better 20.8
No High School Diploma (Age 25+, Percent)	12.3	worse 11.0	better 14.3
Unemployment Rate (Age 16+, Percent)	8.1	similar 7.8	worse 7.4
		better	similar / worse

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2008-2012)



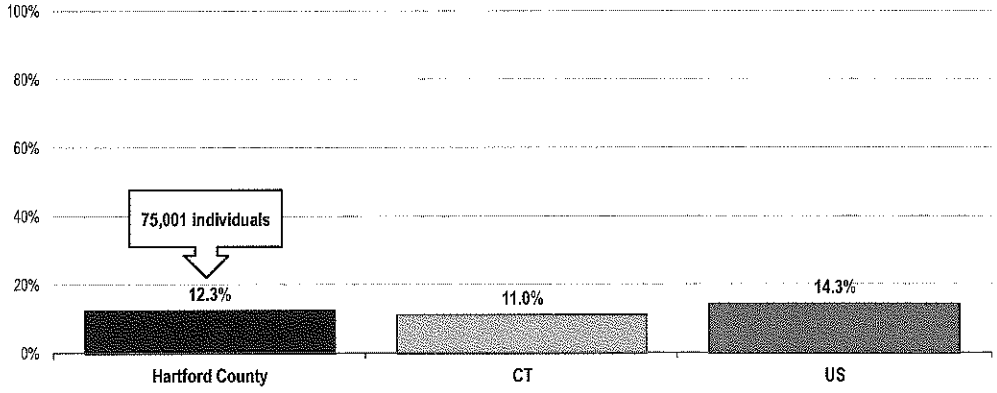
Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education levels are reflected in the proportion of our population without a high school diploma:

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2008-2012)



Sources:
- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

General Health Status

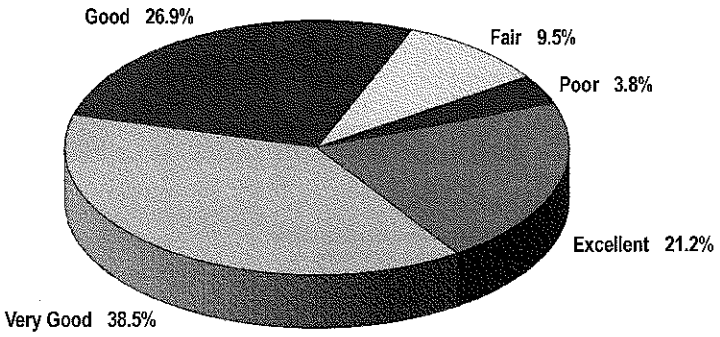
Overall Health Status

Self-Reported Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

"Would you say that in general your health is: excellent, very good, good, fair or poor?"

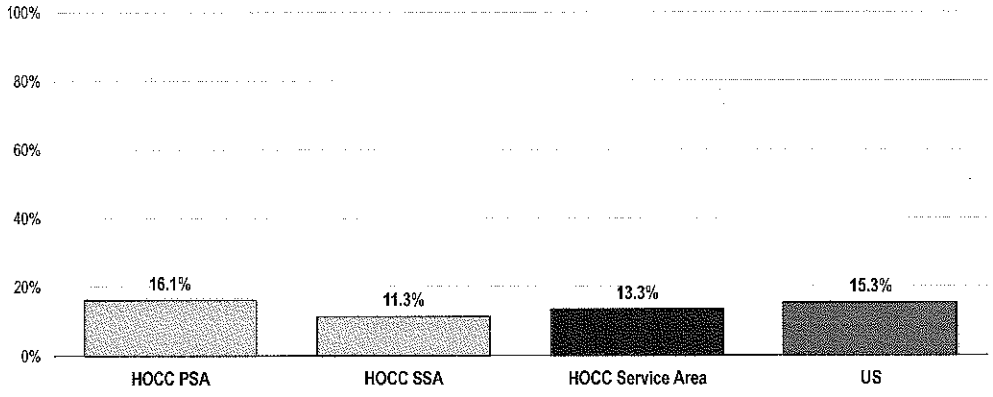
Self-Reported Health Status
(HOCC Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in the Hospital of Central Connecticut Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by gender, age groupings, income [based on poverty status], and race/ethnicity).

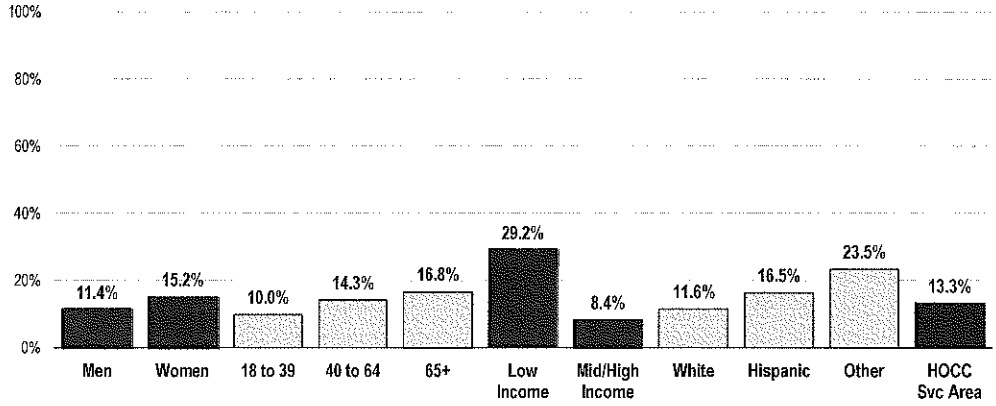
Experience "Fair" or "Poor" Overall Health



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Overall Health

(HOCC Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

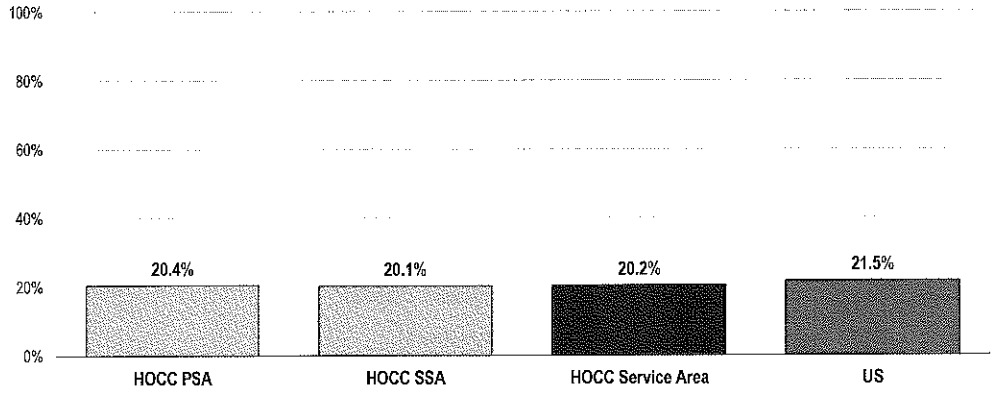
There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

- Healthy People 2020 (www.healthypeople.gov)

"Are you limited in any way in any activities because of physical, mental or emotional problems?"

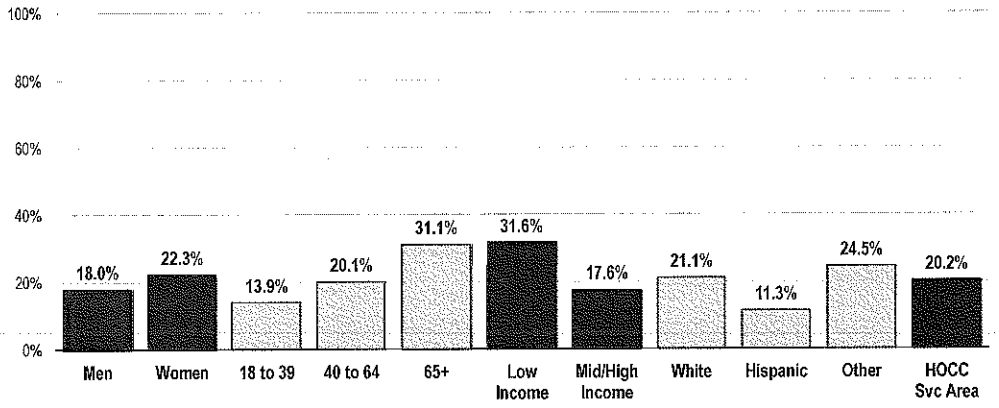
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

(HOCC Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

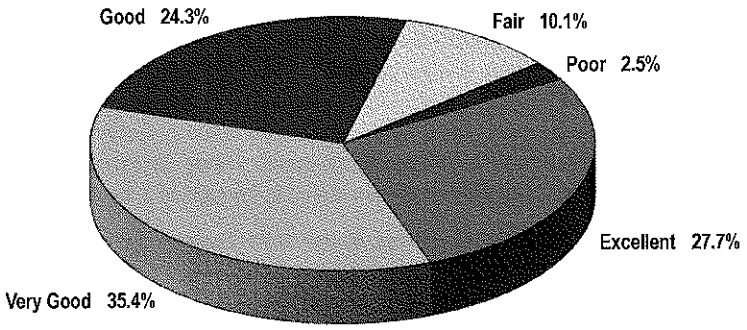
- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

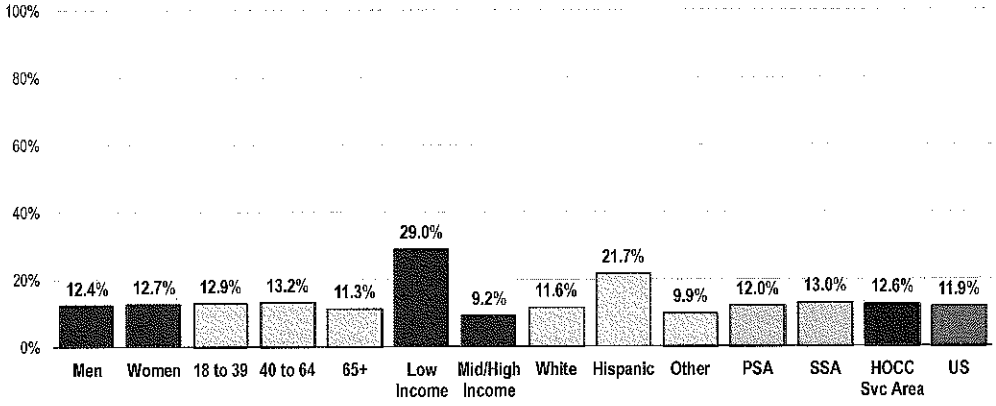
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

Self-Reported Mental Health Status
(HOCC Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Mental Health
(HOCC Service Area, 2015)



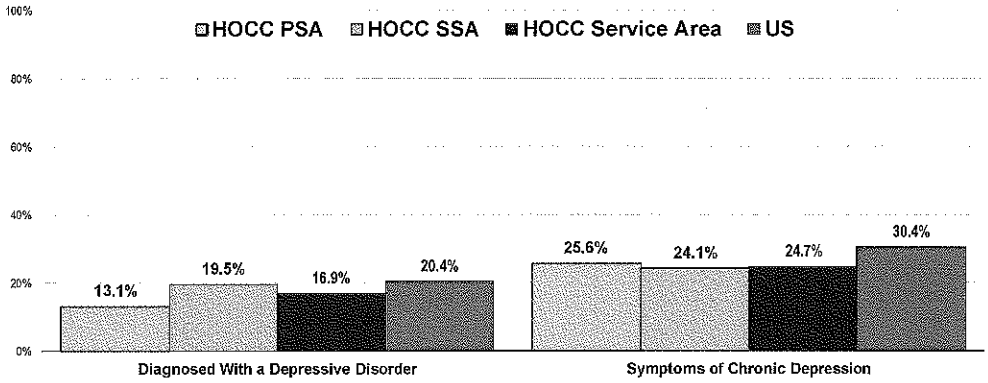
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Depression

Diagnosed Depression: ***"Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"***

Symptoms of Chronic Depression: ***"Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"***

Depression

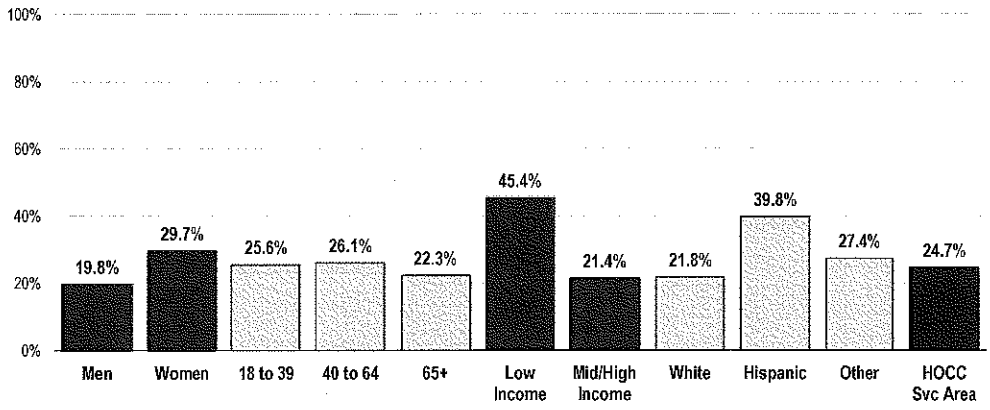


Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 101, 103]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]

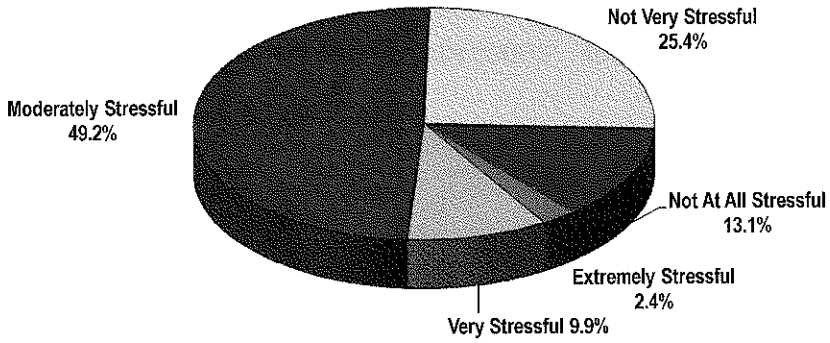
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

"Thinking about the amount of stress in your life, would you say that most days are: Extremely Stressful, Very Stressful, Moderately Stressful, Not Very Stressful or Not At All Stressful?"

Perceived Level of Stress On a Typical Day

(HOCC Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
Notes: • Asked of all respondents.

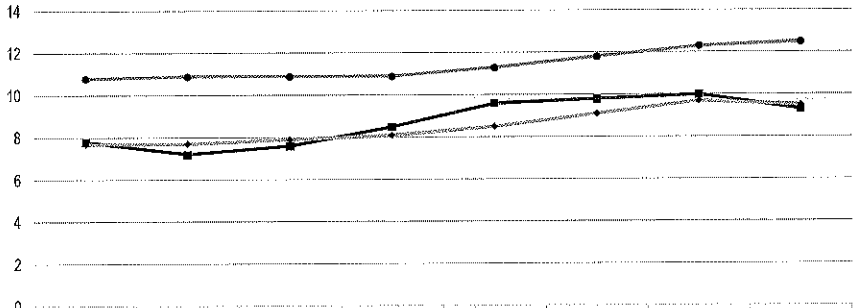
Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. (Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.)

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Hartford County	7.8	7.2	7.6	8.5	9.6	9.8	10.0	9.3
Connecticut	7.7	7.7	7.9	8.1	8.5	9.1	9.7	9.5
United States	10.8	10.9	10.9	10.9	11.3	11.8	12.3	12.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

Mental Health Treatment

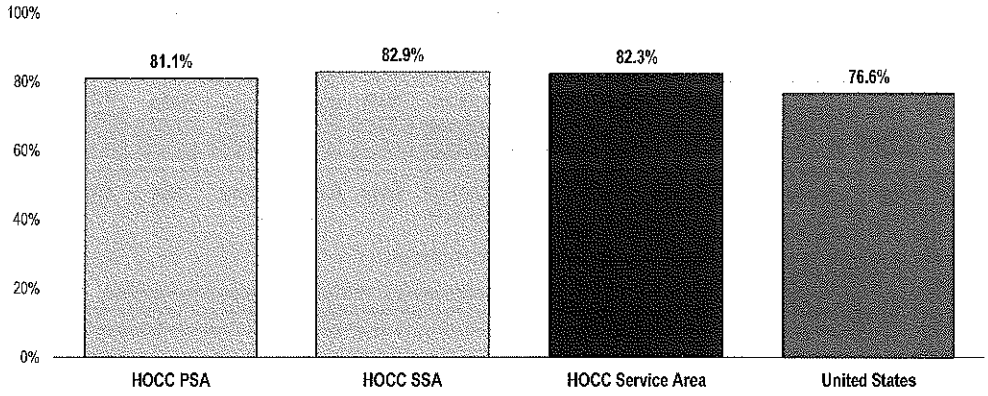
Treatment for Self

"Have you ever sought help from a professional for a mental or emotional problem?"

Note that the first chart shows responses among those with a "diagnosed depressive disorder," which includes respondents reporting a past diagnosis of a depressive disorder by a physician (such as depression, major depression, dysthymia, or minor depression).

Adults With Diagnosed Depression Who Have Ever Sought Professional Help for a Mental or Emotional Problem

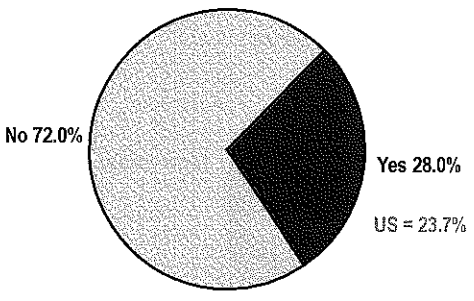
(Among Adults with Diagnosed Depressive Disorder)



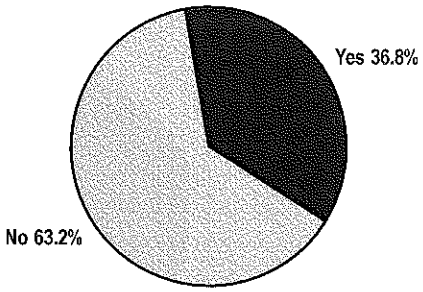
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Reflects those respondents with a depressive disorder diagnosed by a physician (such as depression, major depression, dysthymia, or minor depression).

Adults Seeking Professional Help for Mental Health Issues

(HOCC Service Area, 2015)



Have Sought Professional Help for Mental Health Issues



Sought Help in the Past Year

(Among Those Ever Seeking Help)

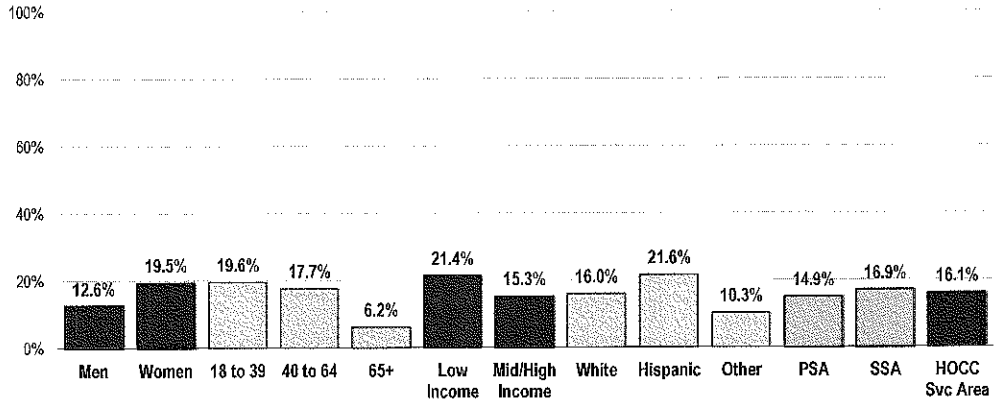
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 104, 310]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Treatment for a Household Member

"During the past 12 months, has anyone in your household sought mental health services??"

Member of Household Sought Professional Help for Mental Health in the Past Year

(HOCC Service Area, 2015)



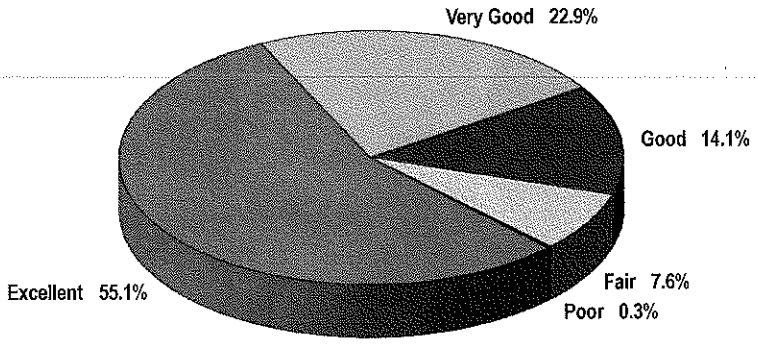
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 311]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children's Mental Health

"Now thinking about this child's mental health, which includes stress, depression, and problems with emotions, would you say that this child's mental health is: excellent, very good, good, fair or poor?"

Child's Reported Mental Health Status

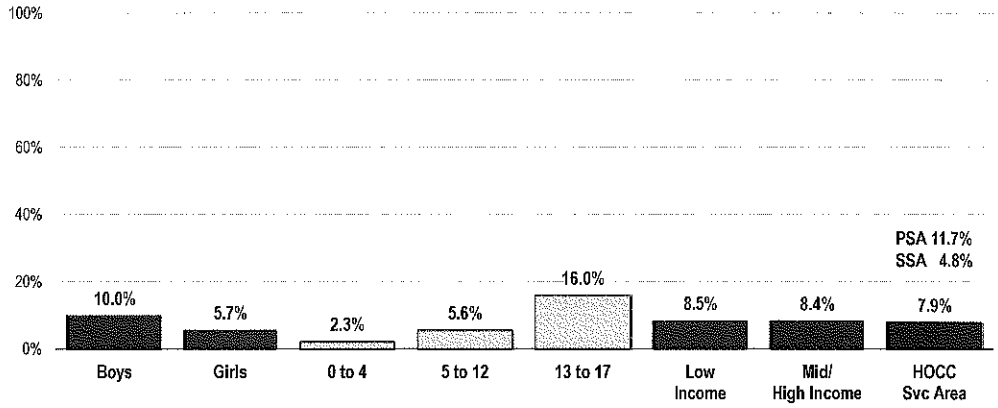
(HOCC Service Area Children <18, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 315]
Notes: • Asked of all respondents with children under 18 at home.

Child Experiences "Fair" or "Poor" Mental Health

(HOCC Service Area Children <18, 2015)

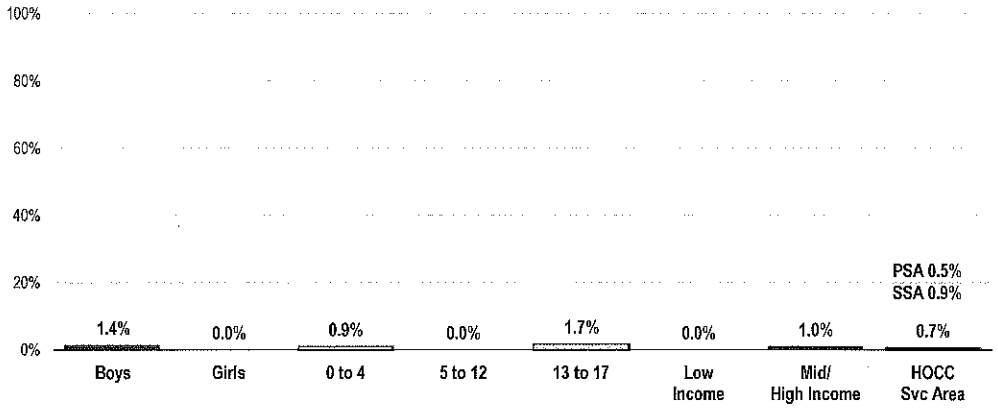


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 315]
Notes: • Asked of all respondents with children under 18 at home.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

"Was there a time in the past 12 months when you needed mental health care for this child, but could not get it?"

Could Not Get Necessary Mental Health Services for Child in the Past Year

(HOCC Service Area Children <18, 2015)

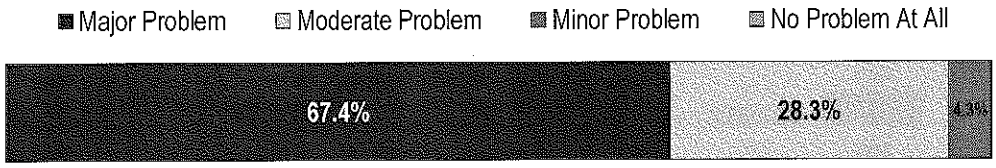


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 316]
Notes: • Asked of all respondents with children under 18 at home.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Challenges

Among those rating this issue as a "major problem," the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care

> *Access to care. Continued long term follow up and transitions of care with chronic disease and mental illness. Limited providers equipped to meet the needs of those with mental illness. Varied approaches to screening for mental illness, including depression, anxiety and their co-existence in chronic disease. – Health Provider (Non-Physician)*
>
> *Accessing affordable services. Accessing mental health providers who understand the needs of lesbian, gay, bisexual and transgender individuals. – Social Services Representative*
>
> *Access. When it comes to treatment of mental health, we look at the problem as if it was a short-term one. Insurance plans may cover four outpatient visits, use of medications as a quick fix, not allowing for mid or long term follow-up. Children and Youth have limited access to inpatient services, residential services, etc. Problems encountered in schools are not often dealt with properly due to limited resources. – Health Provider (Non-Physician)*
>
> *Identification and access. – Community/Business Leader*
>
> *Access to timely quality care and substance abuse treatment resources. – Social Services Representative*
>
> *People with commercial or private insurance often have difficulty accessing participating providers or those who participate have limited capacity. Also, despite parity, benefits are often limited - Health Provider (Non-Physician)*

Lack of Services

> *There is limited community resources. – Health Provider (Non-Physician)*
>
> *Mental Health Services is a much needed service in my community. The waiting list is long in some areas and people are having a multitude if mental health issues that are not being addressed on time. – Social Services Representative*
>
> *Inadequate resources, housing is often a challenge. Family education and support. –*

Community/Business Leader

Lack of access to care, especially pediatric services and what is then covered tied to this care. Day programs are almost always uncovered and almost always the most needed for children. – Physician

In addition to the stigma that is still associated with mental health and addiction issues, there are insufficient services and funding for services to meet the need, especially for children and adolescents. – Community/Business Leader

Stigma

Stigma, lack of resources. – Health Provider (Non-Physician)

Stigma. Lack of access to therapy and medical treatment. Cultural barriers to seeking mental help. Criminalizing the mentally ill. – Public Health Expert

Residential Homes

Approximately 60 State of CT managed Group Home, like residential homes are located in Manchester. Some serve individuals released from Prison for transition through a probation period. Other homes are identified for troubled youth, substance abuse, and a wide variety of behavioral health issues. Access to mental health care is provided to a large extent through services located in Manchester. However, there is a tipping point with the number of individuals being moved to reside in Manchester and the capacity to serve them in the medical community. – Public Health Expert

Access to residential and primary care specialists. – Community/Business Leader

Co-Occurrence With Other Issues

Suicide, depression, alcohol and other substance abuse. – Physician

Many patients have social issues as well as BH issues along with their treating medical chronic condition. Many have substance abuse contributing to their need for BH services. Many are uninsured. – Health Provider (Non-Physician)

At-Risk Populations

Stress and depression are major and disproportionate mental health problems among Latinos, among others. Lack of bilingual mental health professionals is major deficit in the service system. – Social Services Representative

We are seeing increasing numbers of students with mental health and behavioral issues. – Community/Business Leader

Studies/Assessment Findings

Studies/assessments have determined that to be the case. – Community/Business Leader

Case Management and Employment

Access to case management and employment. – Social Services Representative

Significantly Under Detected

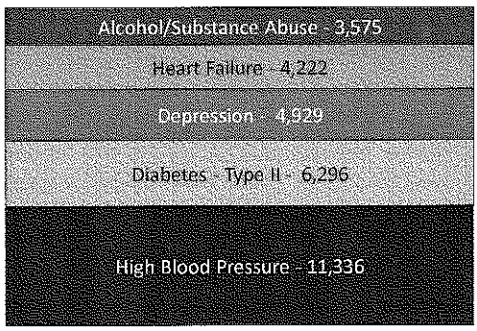
If people are not well mentally they will develop other issues and will potentially hurt others if not treated. – Health Provider (Non-Physician)

Death, Disease & Chronic Conditions

Leading Causes of Hospital Visits

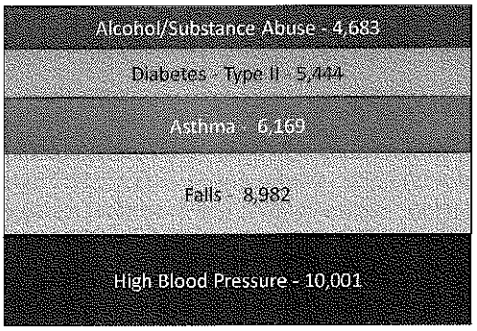
Outlined in the following chart are the top five conditions with the greatest numbers of hospital inpatient visits, as well as emergency visits not resulting in hospital admission.

Top 5 Conditions for Inpatient Hospitalizations



HOCC Service Area

Top 5 Conditions for ED Non-Admissions



HOCC Service Area

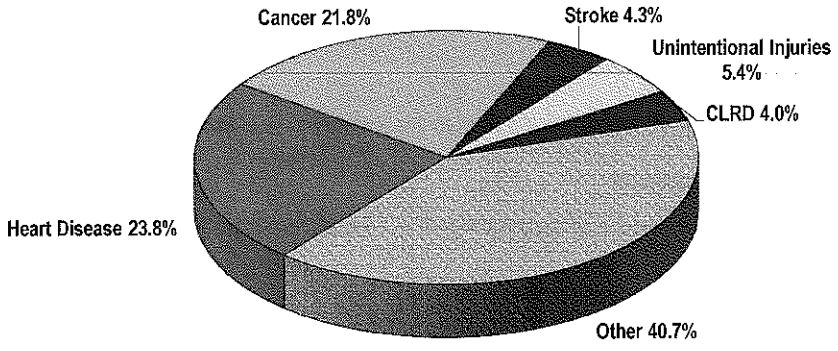
Sources: Connecticut Hospital Association. FY 2013 ChimeData.

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.

Leading Causes of Death
(Hartford County, 2011-2013)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics, Data extracted February 2015.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, the state and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the area. (For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.)

Age-Adjusted Death Rates for Selected Causes

(2011-2013 Deaths per 100,000 Population)

	Hartford County	Connecticut	US	HP2020
Diseases of the Heart	156.5	153.4	171.3	156.9*
Malignant Neoplasms (Cancers)	155.0	153.0	166.2	161.4
Unintentional Injuries	37.8	35.8	39.2	36.4
Chronic Lower Respiratory Disease (CLRD)	30.1	30.9	42.0	n/a
Cerebrovascular Disease (Stroke)	27.0	27.9	37.0	34.8
Alzheimer's Disease	17.4	16.5	24.0	n/a
Kidney Diseases	14.7	12.5	13.2	n/a
Pneumonia/Influenza	14.2	12.9	15.3	n/a
Diabetes Mellitus	13.9	14.8	21.3	20.5*
Drug-Induced	13.6	13.5	14.1	11.3
Intentional Self-Harm (Suicide)	9.3	9.6	12.5	10.2
Cirrhosis/Liver Disease	8.5	7.6	9.9	8.2
Motor Vehicle Deaths	8.4	7.1	10.7	12.4
Firearm-Related	5.8	5.5	10.4	9.3
Homicide/Legal Intervention	4.1	3.8	5.3	5.5
HIV/AIDS	2.9	2.0	2.2	3.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
- Local, state and national data are simple three-year averages.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

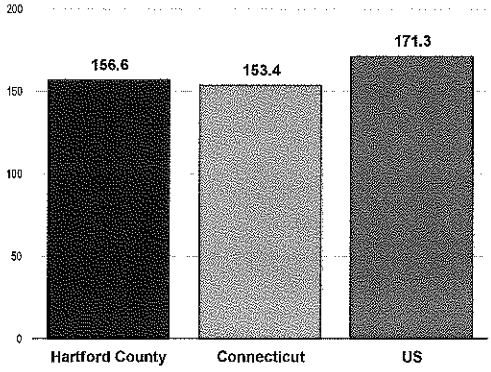
Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

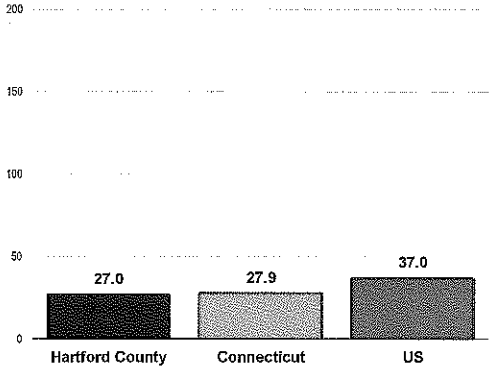
Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

Heart Disease: Age-Adjusted Mortality
(2011-2013 Deaths per 100,000 Population)
Healthy People 2020 Target = 158.9 or Lower (Adjusted)



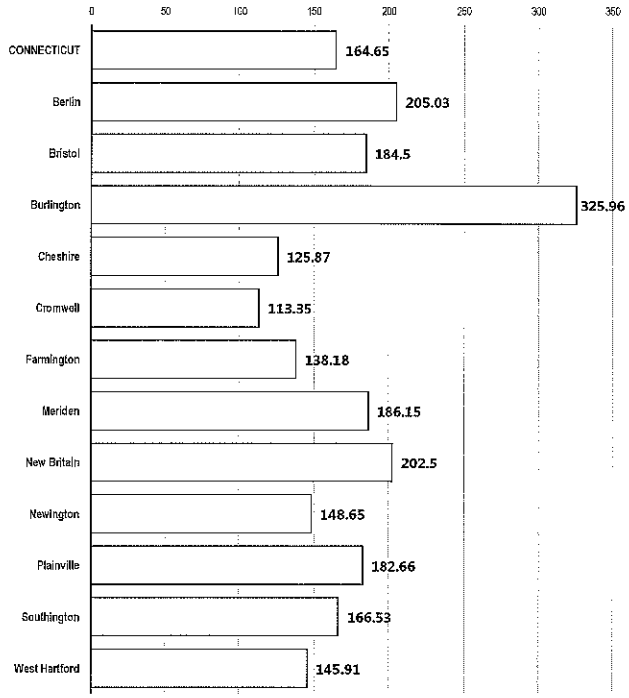
Stroke: Age-Adjusted Mortality
(2011-2013 Deaths per 100,000 Population)
Healthy People 2020 Target = 33.8 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2015.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives HDS-2 and HDS-3]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

The following charts show available local death rates (age-adjusted) for select towns in the Hospital of Central Connecticut Service Area.

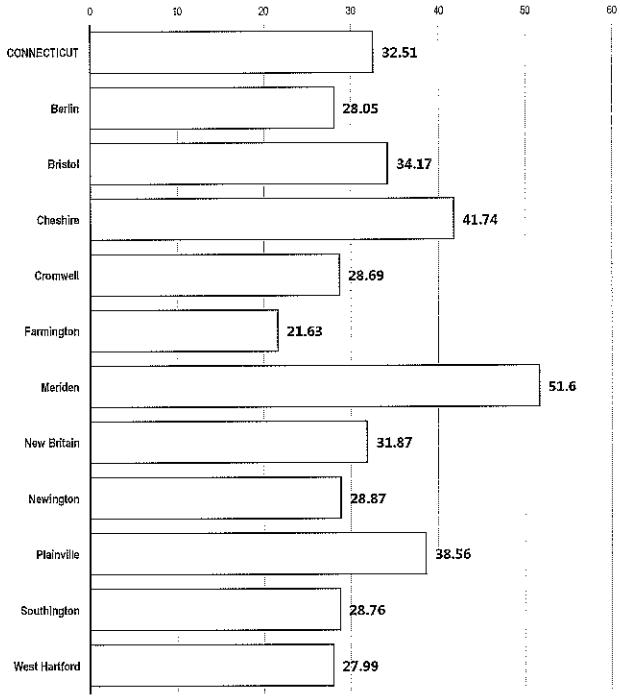
Heart Disease: Age-Adjusted Mortality
(By Select Towns in the HOCC Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

Stroke: Age-Adjusted Mortality

(By Select Towns in the HOCC Service Area, 2006-2010)



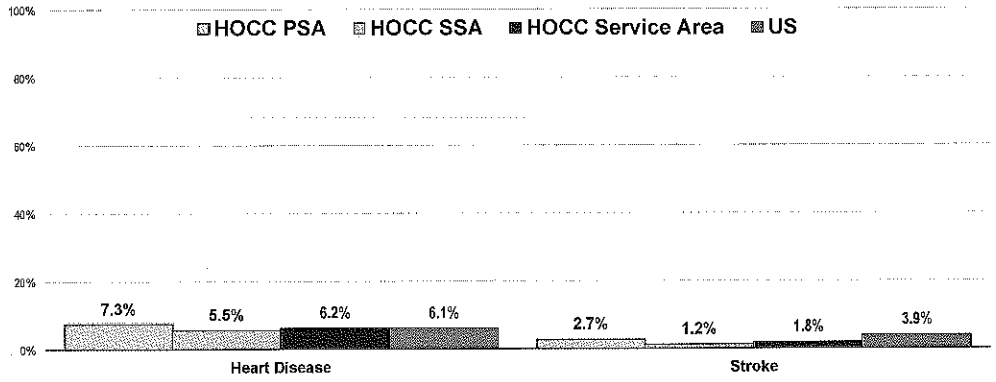
Source: • Connecticut Department of Public Health

Prevalence of Heart Disease & Stroke

"Has a doctor, nurse or other health professional ever told you that you had: A Heart Attack, Also Called a Myocardial Infarction; or Angina or Coronary Heart Disease?" (Heart disease prevalence below is a calculated prevalence that includes those responding affirmatively to either.)

"Has a doctor, nurse or other health professional ever told you that you had a stroke?"

Prevalence of Heart Disease & Stroke



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 36, 124]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Heart disease includes diagnoses of heart attack, angina or coronary heart disease.

Cardiovascular Risk Factors

About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

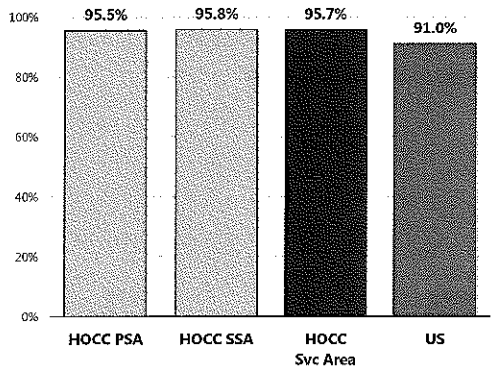
- Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure & Cholesterol Testing

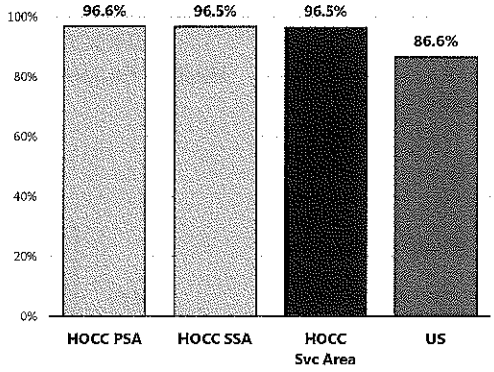
"About how long has it been since you last had your blood pressure taken by a doctor, nurse or other health professional?" (Chart below reflects responses indicating testing within the past 2 years.)

"About how long has it been since you last had your blood cholesterol checked?" (Chart below reflects responses indicating testing within the past 5 years.)

Blood Pressure
Checked in the Past 2 Years
Healthy People 2020 Target = 92.6% or Lower



Blood Cholesterol
Checked in the Past 5 Years
Healthy People 2020 Target = 82.1% or Lower



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 45, 48]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives HDS-4, HDS-6]

High Blood Pressure & Cholesterol Prevalence

"Have you ever been told by a doctor, nurse or other health care professional that you had high blood pressure?

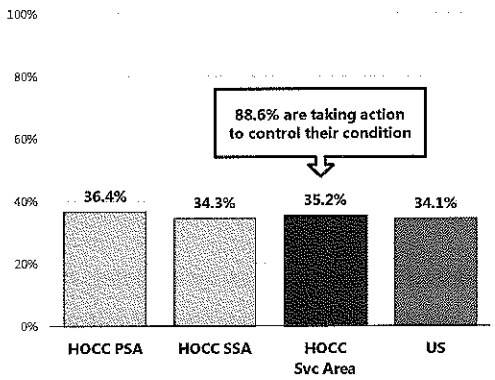
- *"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"*

"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

- *"Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"*

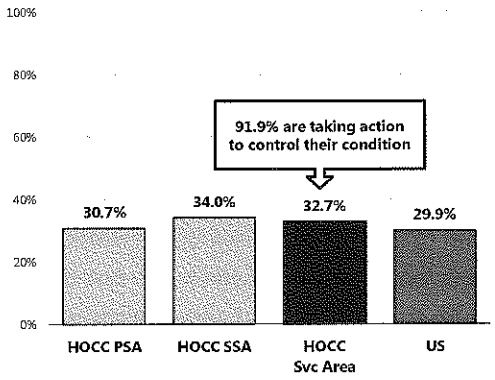
Prevalence of High Blood Pressure

Healthy People 2020 Target = 26.9% or Lower



Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



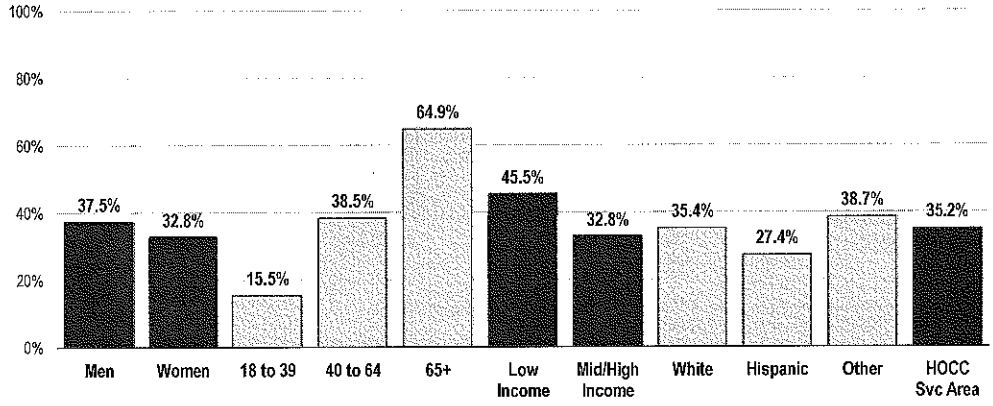
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 44, 47, 125, 126]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives HDS-5.1 and HDS-7]

Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure

(HOCC Service Area, 2015)

Healthy People 2020 Target = 26.9% or Lower



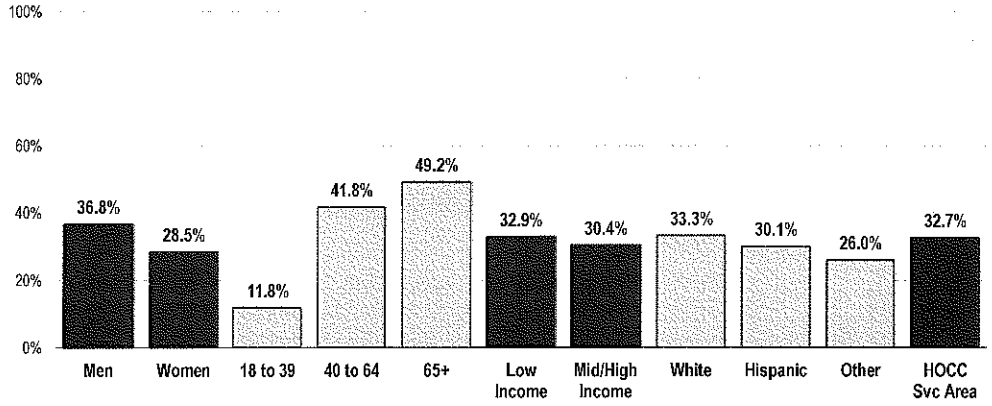
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prevalence of High Blood Cholesterol

(HOCC Service Area, 2015)

Healthy People 2020 Target = 13.5% or Lower



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 126]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

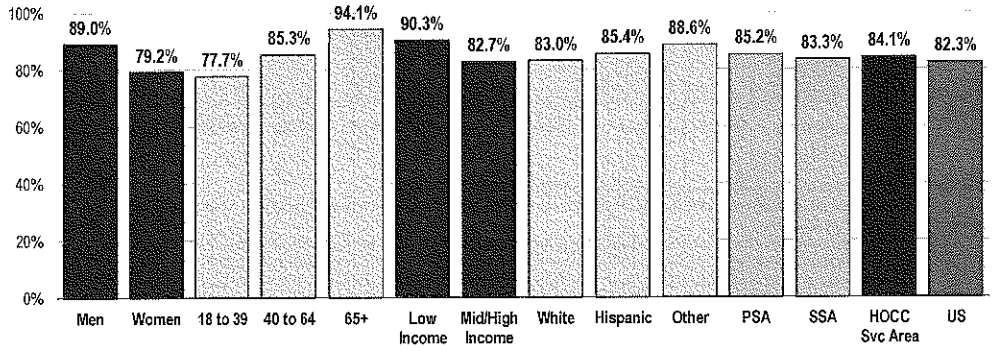
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

The following chart reflects the percentage of adults in the Total Service area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the Modifiable Health Risk section of this report.

Present One or More Cardiovascular Risks or Behaviors

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

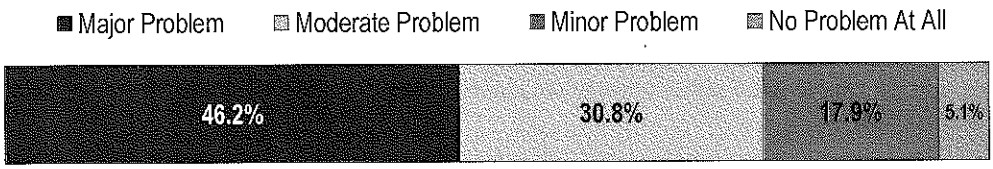
Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease and Stroke as a Problem in the Community

(Key Informants, 2015)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Leading Cause of Death, Prevalence

> *Continues to be in the top five houses of death in our city. – Public Health Expert*
>
> *Data show. – Physician*
>
> *Can lead to death and other life-threatening and expensive to treat illnesses. – Health Provider (Non-Physician)*
>
> *Heart disease is the leading cause of death among minorities in the United States, according to the U.S. Department of Health and Human Services Office of Minority Health. Blacks and Hispanics are more likely to suffer from obesity and hypertension, two of the major risk factors for heart disease. – Health Provider (Non-Physician)*
>
> *Lead cause of death. – Public Health Expert*
>
> *Studies/assessments have determined that to be the case. – Community/Business Leader*

Nutrition, Physical Activity & Weight

> *Bad habits of today, that offer immediate gratification, leads to these health risks down the road. Stress, poor diets, lack of exercise (no time) are all becoming more a part of our lives. Primary Care can address some challenges when people have coverage and can make their co-payments, but our society has become more "give me what I want now, I'll deal with the consequences later." While school meals seem to be improving for our children, the pressure to improve testing scores has led to the elimination of recess and cut down on physical education/activity in many school systems, another example of what we deem to be our priority. – Health Provider (Non-Physician)*
>
> *Poor diet and exercise. Lack of education. Poor parks and recreation options. Poor urban planning, community infrastructure, barrier to physical activity. Food, desserts. – Public Health Expert*
>
> *There is a high prevalence of obesity in Hartford which is linked to heart disease. Further there are a number of barriers to accessing nutritious food which make it difficult for families to eat regular balanced nutritious meals. – Community/Business Leader*
>
> *High-stress lifestyles, lack of exercise, lack of access to and affordability of healthy foods, heavy smoking and consuming alcoholic beverages in excess. – Social Services Representative*
>
> *Poverty, inadequate diets, not taking the problem serious. – Social Services Representative*

At-Risk Populations

> *African Americans and Hispanics which make up a large percentage of the Hartford population are often affected by heart disease and stroke. Reasons being due to genetics, but largely because of a poor unbalanced diet which contains a vast amount carbohydrates, fats and sodium and not enough grains, fruits and vegetables. – Health Provider (Non-Physician)*
>
> *With the high rates of diabetes in the city, the risk for heart disease and stroke is also elevated. – Community/Business Leader*
>
> *Heart disease and stroke in the community are usual as result of another chronic disease not being managed. – Social Services Representative*
>
> *Individuals who cannot afford care often go untreated with progression of disease states. Limited ability to refer patients to cardiology related to uninsured status. – Health Provider (Non-Physician)*

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

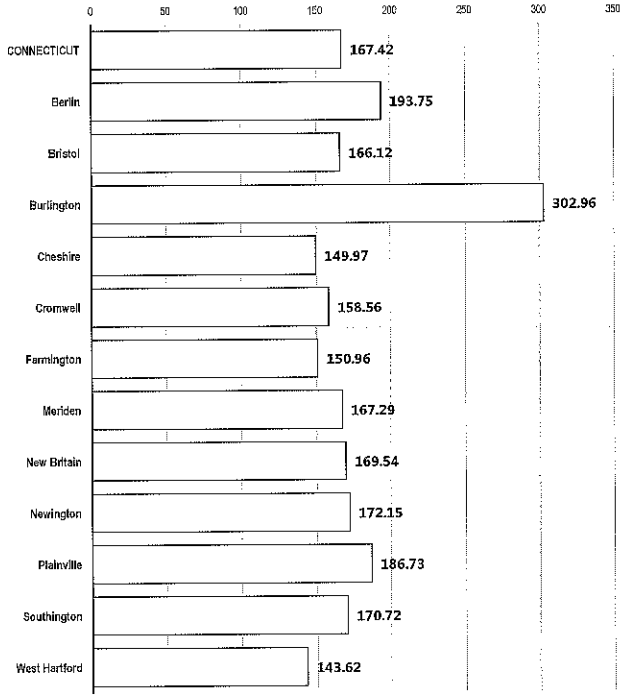
- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted mortality in select towns in the Hospital of Central Connecticut Service Area.

Cancer: Age-Adjusted Mortality
(By Select Towns in the HOCC Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

Lung cancer is by far the leading cause of cancer deaths in the area. Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).

Age-Adjusted Cancer Death Rates by Site

(2011-2013 Annual Average Deaths per 100,000 Population)

	Hartford County	Connecticut	US	HP2020
Lung Cancer	38.3	38.7	44.7	45.5
Prostate Cancer	20.7	18.2	19.8	21.8
Female Breast Cancer	19.4	19.2	21.3	20.7
Colorectal Cancer	12.9	12.1	14.9	14.5

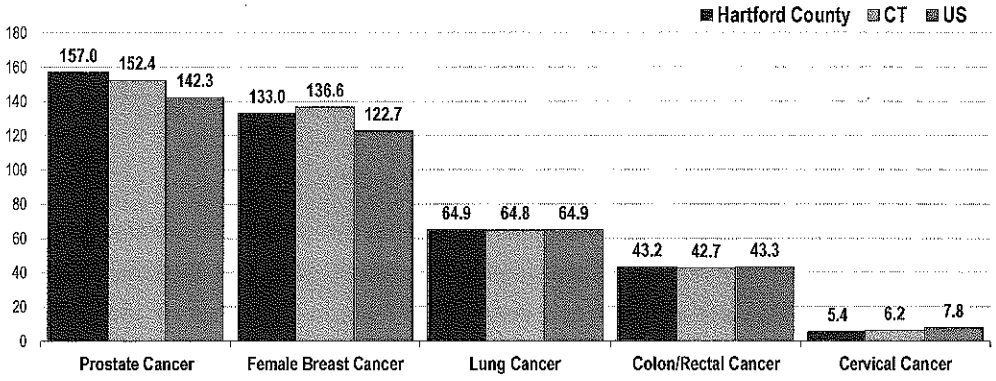
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They are usually expressed as cases per 100,000 population per year. Here, these rates are also age-adjusted.

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2007-2011)



Sources:
- State Cancer Profiles: 2007-11.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

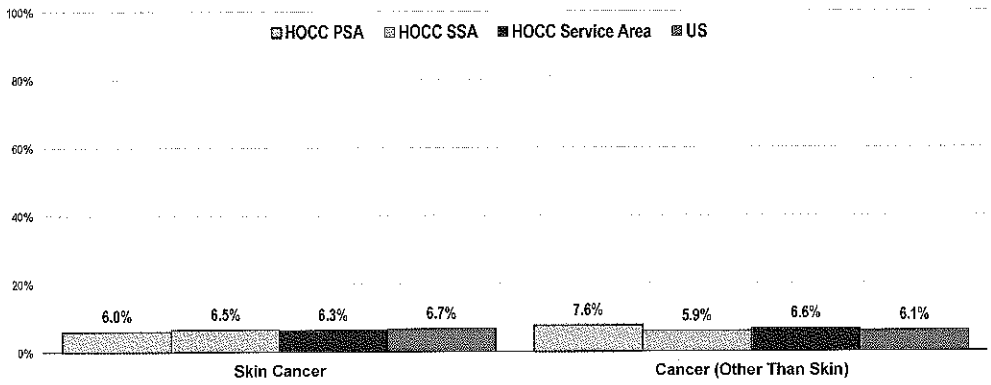
Prevalence of Cancer

Skin Cancer

"Would you please tell me if you have ever suffered from or been diagnosed with cancer, not counting skin cancer?"

"Would you please tell me if you have ever suffered from or been diagnosed with skin cancer?"

Prevalence of Cancers



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 30, 31]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Cancer Risk

About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

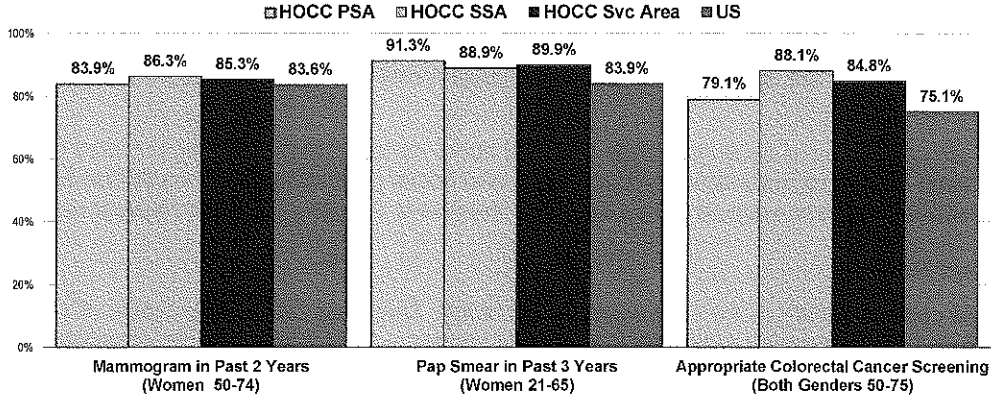
Breast Cancer Screening: ***"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"*** (Calculated below among women age 50 to 74 indicating screening within the past 2 years.)

Cervical Cancer Screening: ***"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"*** (Calculated below among women age 21 to 65 indicating screening within the past 3 years.)

Colorectal Cancer Screening: ***"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"*** and ***"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"*** (Calculated below among both genders age 50 to 75 indicating fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)

Cancer Screenings

Healthy People 2020 Target = 81.1% or Higher (Mammograms)
Healthy People 2020 Target = 93.0% or Higher (Pap Smears)
Healthy People 2020 Target = 70.5% or Higher (Colorectal)



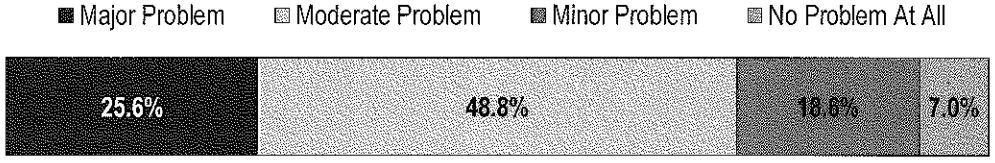
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 128-130]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives C-15, C-16, and C-17]

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:

Perceptions of Cancer as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Prevention & Early Detection

> *Not enough cancer prevention programs in the community. – Public Health Expert*
>
> *Due to lack of screening for early detection purposes. Not because of lack of availability but rather because of lack of education to access the services. – Community/Business Leader*
>
> *Very low income. People don't get to the doctor for preventative or early detection services so don't seek treatment until they have advanced illness. – Social Services Representative*

> *Poor access to screening. Poor adherence to screening guidelines. Late detection, unnecessarily high mortality rates. – Public Health Expert*

At-Risk Populations

> *It's a major problem in communities of color. There are more and more people who are diagnosed. – Social Services Representative*
>
> *People of color are desperately impacted in most forms of cancer. – Health Provider (Non-Physician)*
>
> *While Latinos have lower incidence rates for some cancers, they have higher rates for some others. They also have later detection rates and social determinants of health that impede adequate wellness support during and after treatment. – Social Services Representative*

High Cancer Rates

> *This case of cancer in the community are growing. There are lack of knowledge of education, prevent and screening regarding the issue of cancer. – Social Services Representative*
>
> *Data show it to be. – Physician*

Cost of Cancer Medications

> *There is very good hospital based care and treatment but the drug costs are soaring and with high deductible plans patients are more and more responsible for the expense and it has caused access issues, as has the reduced Medicare and commercial insurer reimbursement for the drugs and the associated administration of the drugs. Most of these drugs require administration by trained medical professionals. – Physician*

Access to Specialists

> *There is little access locally to specialists. – Community/Business Leader*

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 (www.healthypeople.gov)

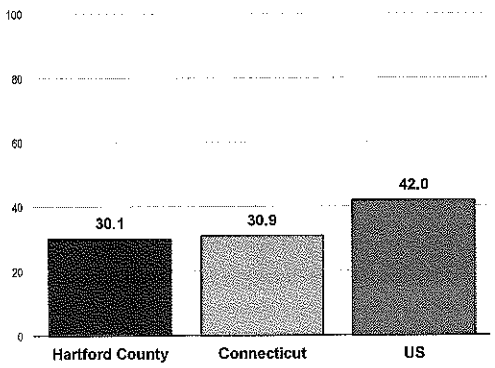
[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

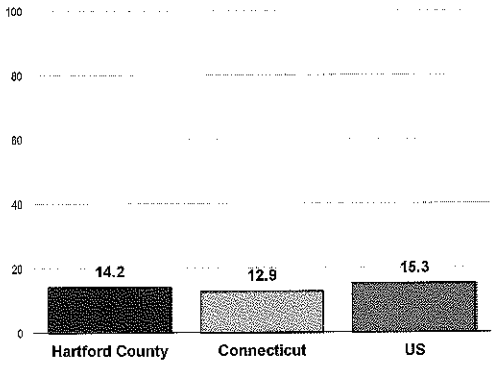
Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis.

Pneumonia and influenza mortality is also illustrated in the following chart. For prevalence of vaccinations against pneumonia and influenza, see also *Immunization & Infectious Disease*.

Chronic Lower Respiratory Disease: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)



Pneumonia/Influenza: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)

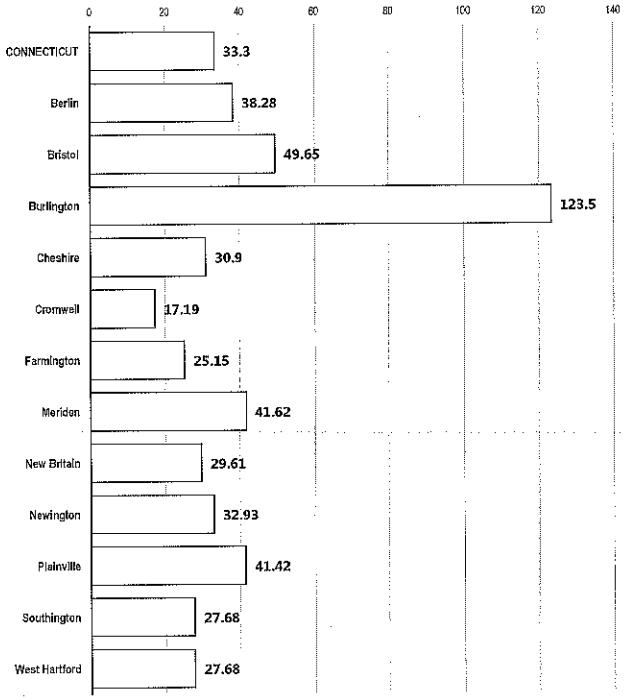


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2015.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.

Town-level mortality rates are shown below.

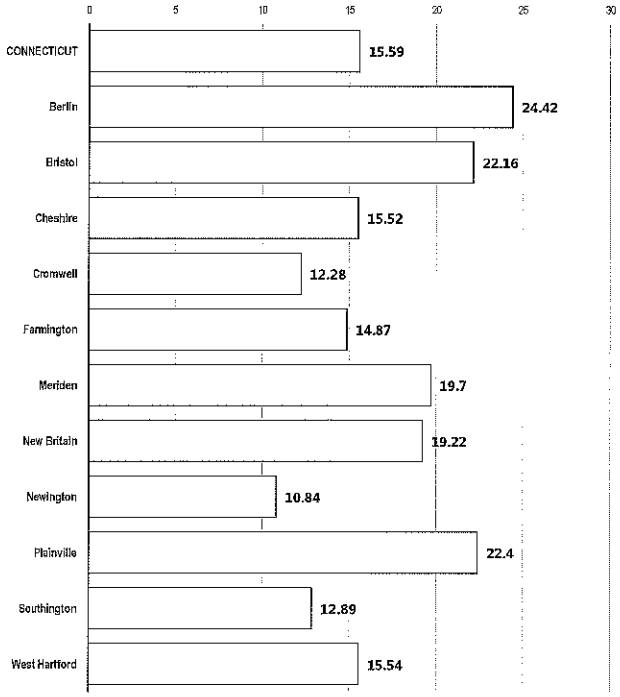
CLRD: Age-Adjusted Mortality
(By Select Towns in the HOCC Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

Influenza/Pneumonia: Age-Adjusted Mortality

(By Select Towns in the HOCC Service Area, 2006-2010)



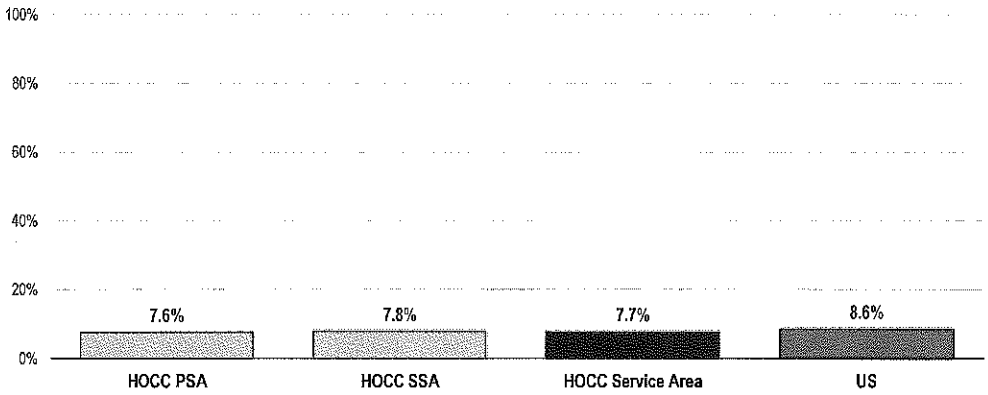
Source: • Connecticut Department of Public Health

Prevalence of Respiratory Diseases

COPD

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



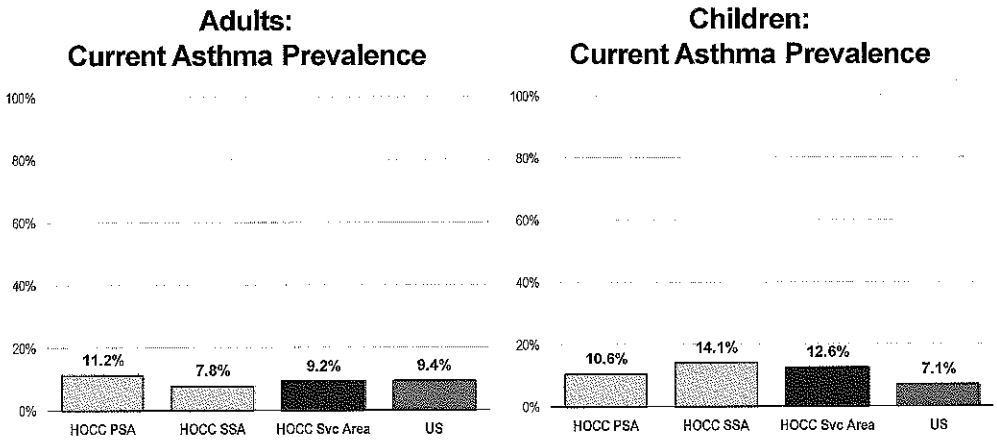
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 25]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
• Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

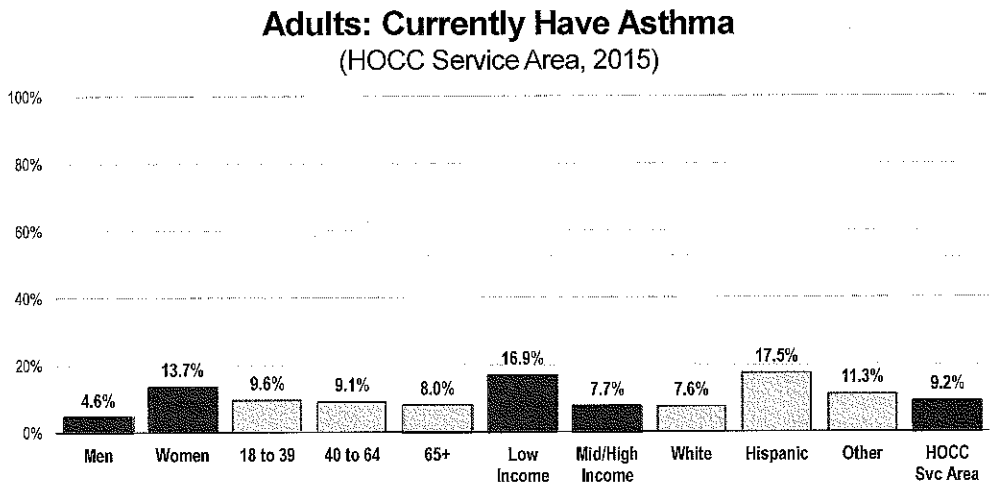
Asthma

Adults: ***"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?"*** and ***"Do you still have asthma?"*** (Calculated below as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).

Children: ***"Has a doctor or other health professional ever told you that this child had asthma?"*** and ***"Does this child still have asthma?"*** (Calculated below as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 134, 135]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

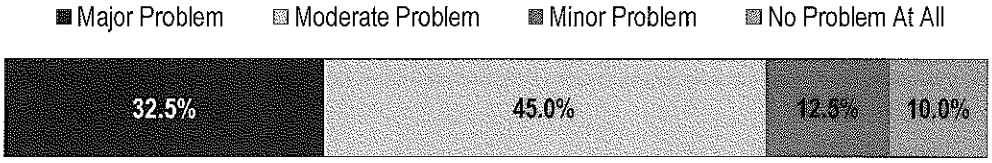


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 134]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Diseases as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Asthma

> *Asthma. – Physician*
>
> *Very high rates of asthma. 40% or more for students in our schools. – Community/Business Leader*
>
> *Can be life threatening. – Health Provider (Non-Physician)*
>
> *Tobacco use. Poor indoor air quality. Lack of affordable housing. High asthma rates. – Public Health Expert*

Pollution

> *This is primarily due to the excessive amount of pollution in the community. – Health Provider (Non-Physician)*

Disease Management

> *Patients not following the doctor's orders and follow up care. – Health Provider (Non-Physician)*

At-Risk Populations

> *Latinos in CT suffer disproportionate rates of asthma and of inadequate asthma management. – Social Services Representative*

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

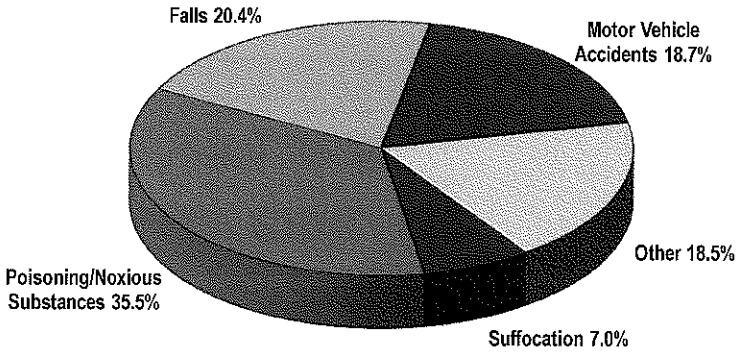
- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Leading causes of accidental death in the area include the following:

Leading Causes of Accidental Death
(Hartford County, 2011-2013)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

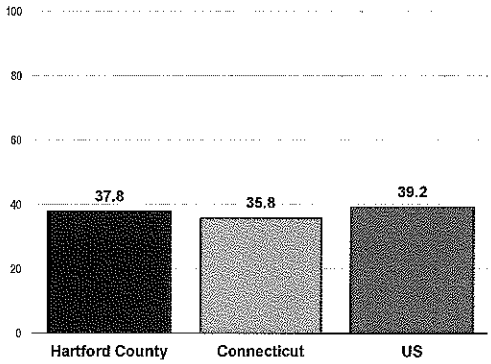
Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

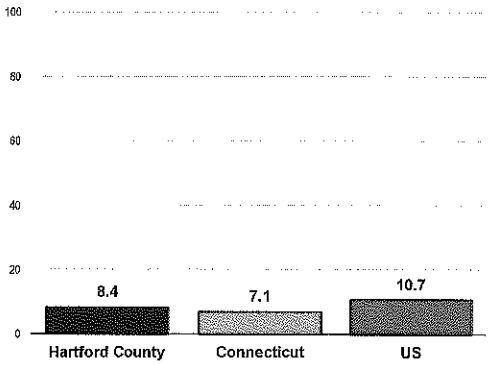
The following chart outlines age-adjusted mortality rates for unintentional injury in the area, including age-adjusted mortality rates attributed specifically to motor vehicle crashes.

- Note the Healthy People 2020 targets.

Unintentional Injury: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 36.0 or Lower



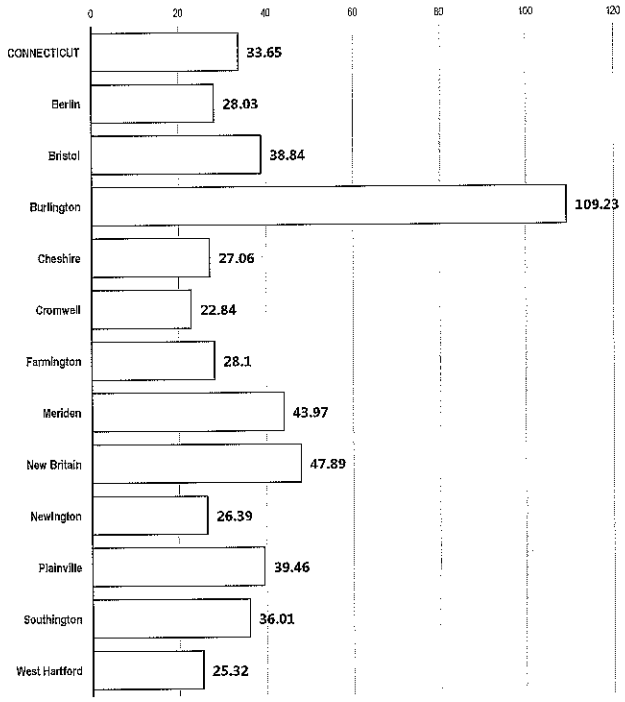
Motor Vehicle Crashes: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 12.4 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2015.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IVP-11 and IVP-13.1]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

Town-level mortality for unintentional injury is shown below.

Unintentional Injury: Age-Adjusted Mortality
(By Select Towns in the HOCC Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

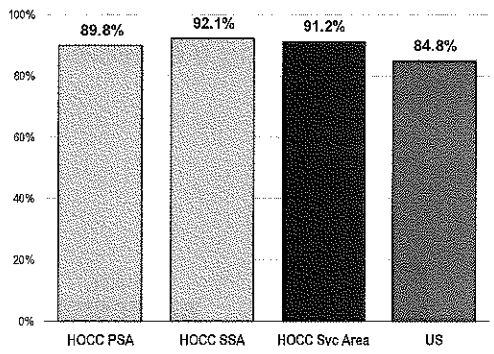
Seat Belt/Car Seat Usage

Adults: ***"How often do you use seat belts when you drive or ride in a car? Would you say: always, nearly always, sometimes, seldom, or never?"***

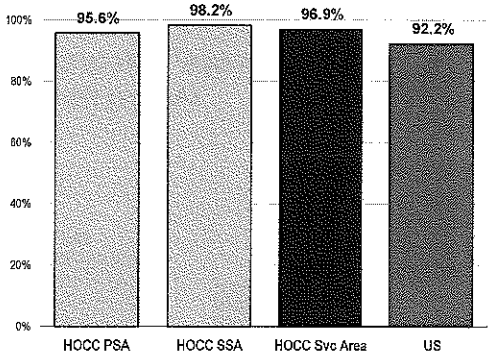
Children: ***"How often does this child wear a child restraint or seat belt when riding in a car? Would you say: always, nearly always, sometimes, seldom, or never?"***

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle

Healthy People 2020 Target = 92.0% or Higher



Child "Always" Uses Appropriate Safety Restraint (Seat Belt/Car Seat) When Riding in a Vehicle



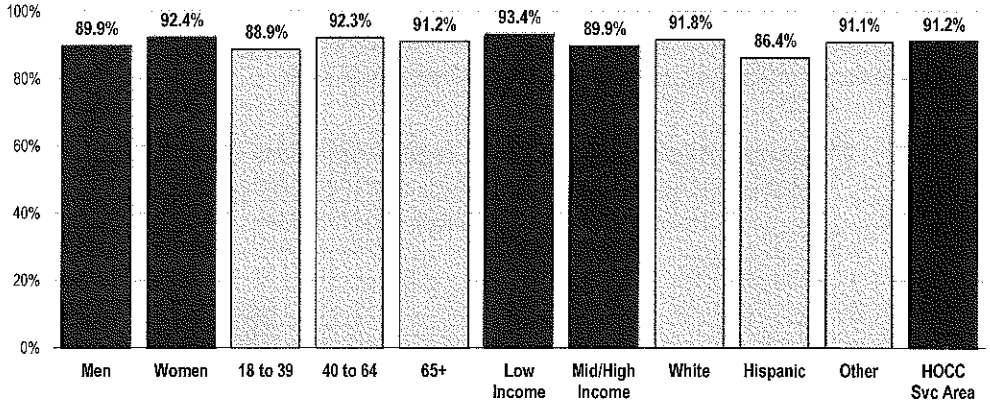
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 49 and 122]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

Notes:
- Asked of all respondents.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle

(HOCC Service Area, 2015)

Healthy People 2020 Target = 92.0% or Higher



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-15]

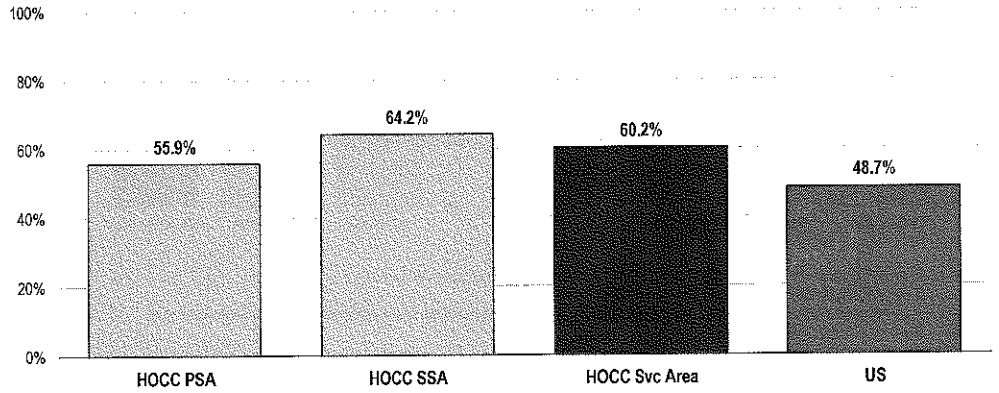
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Bicycle Safety

Children Age 5-17: ***"In the past year, how often has this child worn a bicycle helmet when riding a bicycle? Would you say: always, nearly always, sometimes, seldom, or never?"***

Child "Always" Wears a Helmet When Riding a Bicycle

(Among Parents of Children Age 5-17)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children age 5 to 17 at home.

Firearms

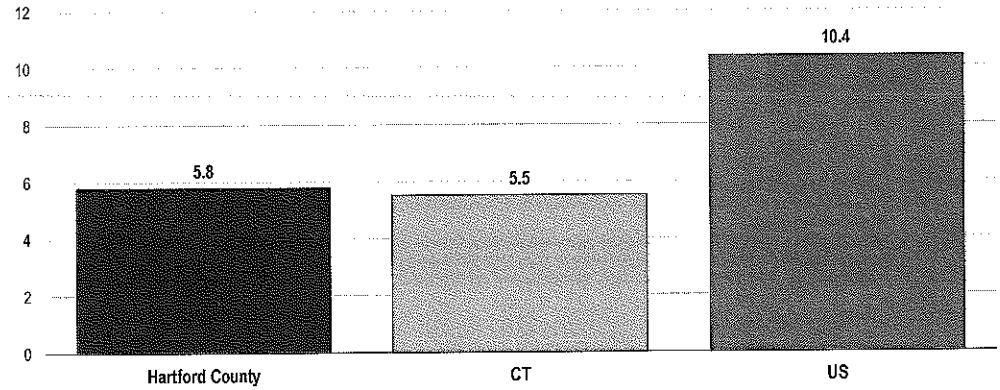
Age-Adjusted Firearm-Related Deaths

The following chart outlines the age-adjusted mortality rate in the area attributed to firearms (including both accidental and intentional discharge), compared to state and national rates.

Firearms-Related Deaths: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Local, state and national data are simple three-year averages.

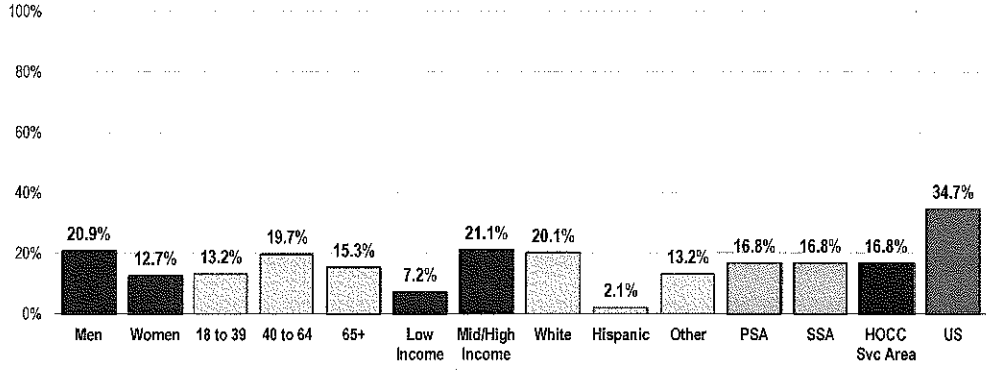
Presence of Firearms in Homes

"Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, 'firearms' include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire."

"An unlocked firearm is one that does NOT need a key or combination to get to the gun or fire it. The safety is NOT counted as a lock. Are any of these firearms unlocked?" and ***"Are any of these unlocked firearms now loaded?"*** (Calculated below as the percentage of respondents who have firearms at home and who keep at least one firearm unlocked and loaded.)

Have a Firearm Kept in or Around the House

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

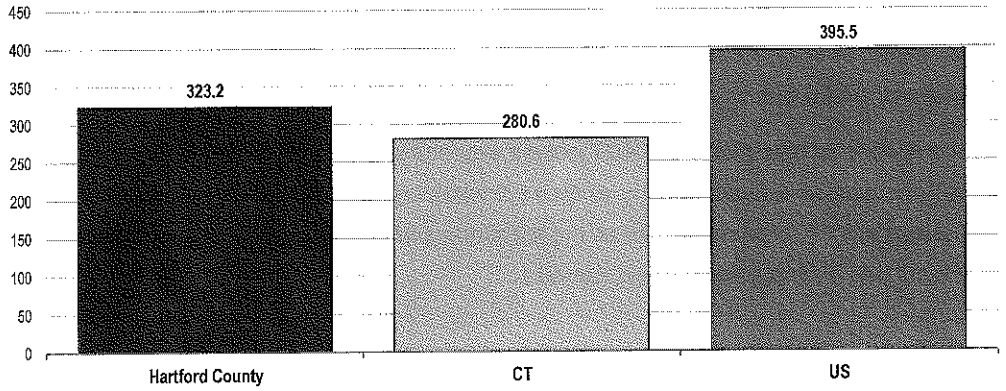
Intentional Injury (Violence)

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime

(Rate per 100,000 Population, 2010-2012)



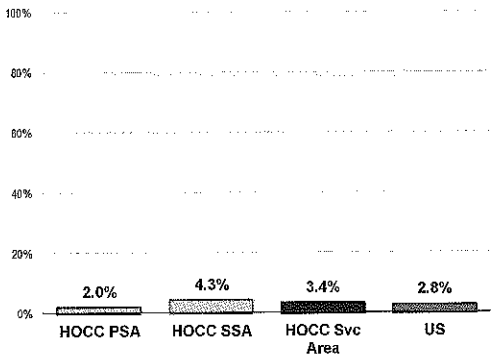
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports: 2012.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

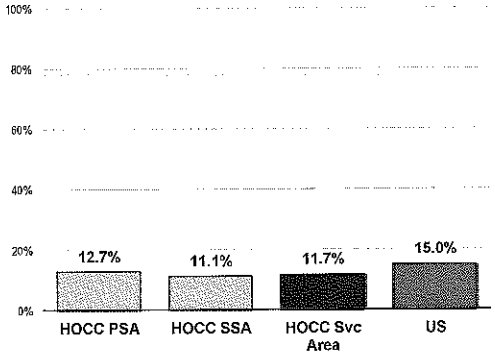
Violent Crime Experience: ***"Have you been the victim of a violent crime in your area in the past 5 years?"***

Intimate Partner Violence: ***"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"***

Victim of a Violent Crime in the Area in the Past Five Years



Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt In Any Way by an Intimate Partner



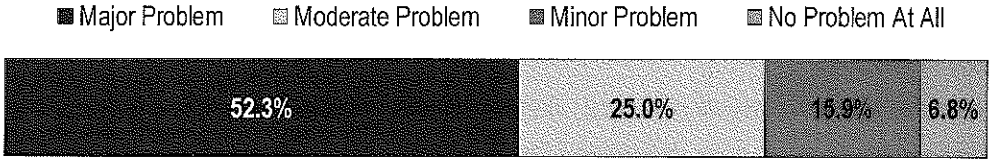
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 50, 51]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Gang Activity & Youth Violence

> *Every day there are people in my community either getting killed or injured due to guns, gang related matters, drug problems, etc. – Social Services Representative*
>
> *We have a lot of gang activity. – Health Provider (Non-Physician)*
>
> *There is a high prevalence of community violence and gang involvement in Hartford. Many young people are negatively influenced by peers and end up in unsafe situations. Many residents do not feel safe because of the violence and research has demonstrated the impact of high levels of community violence on child development and the stress that it creates which is can impact social/emotional development and wellbeing. – Community/Business Leader*
>
> *Our students are affected by high rates of violence in our community. – Community/Business Leader*

Environment & Economic Stressors

> *Hartford is an urban center with a significantly economically stressed population. Injury and violence statistics vary by neighborhood, but are above state averages. – Community/Business Leader*
>
> *Poverty, people have many daily issues and they used substances, have little hope and are frustrated with their life and then resort to utilizing poor skills. – Health Provider (Non-Physician)*
>
> *I believe that there is more harm done to children through intentional or unintentional injury than any childhood illness. The long term effects of being exposed to violence at an early age is not something we measure, but impacts our health system, educational system and judicial system. Access to weapons is a problem when mixed with stress, poverty, etc. Many unintentional injuries are easily preventable, but a hurried lifestyle along with "it won't happen to me" attitude are bad combinations. – Health Provider (Non-Physician)*
>
> *Unsafe housing conditions. Lack of safe play spaces. Young parents with lack of parenting skills, abuse and neglect. – Public Health Expert*

Domestic Violence

> *Domestic violence is an ongoing issue and more needs to be done tied to helping physicians and other clinicians identify and then help direct patients who have been a victim of domestic violence. There is also a need for interpreter services tied to communicating with those often who have been abused. – Physician*
>
> *Domestic violence and youth violence. – Community/Business Leader*
>
> *Many of these are preventable, so you would expect to see this decreasing as knowledge is disseminated. Instead we see family violence and unintentional injuries repeated generation after generation. – Social Services Representative*

Prevalence of Violence

> *Homicide and other intentional injury. Alcohol-related injury. – Physician*
>
> *Studies/assessments have determined that to be the case. – Community/Business Leader*

Homelessness

> *The community I am referring to is those experiencing or at risk of homelessness. For women and families, domestic violence is often related to episodes of homelessness. Also, for those experiencing homelessness, the threat of injury and violence is a significant issue. – Community/Business Leader*

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

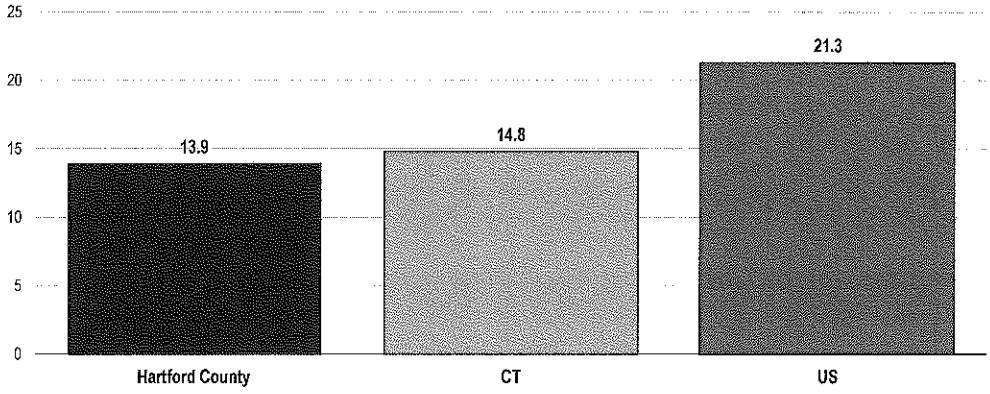
Age-adjusted diabetes mortality for the area is shown in the following chart.

- Note the Healthy People 2020 target (as adjusted to account for diabetes mellitus-coded deaths).

Diabetes: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)

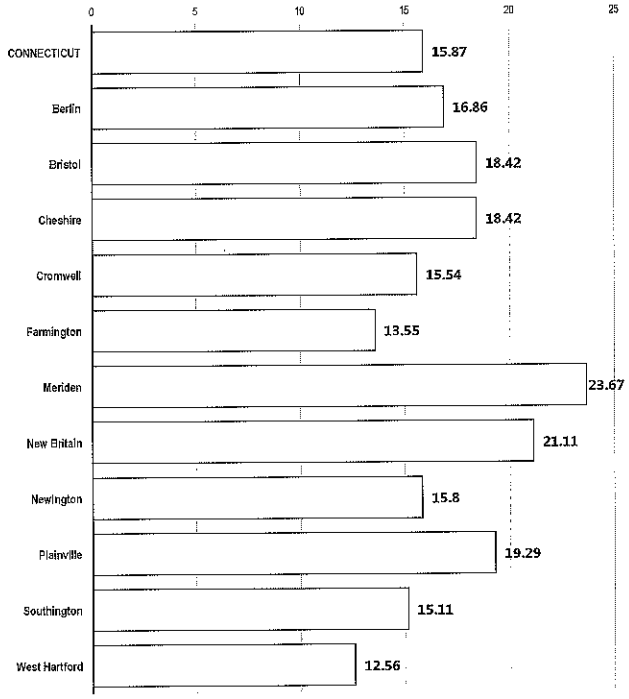


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Local diabetes mortality for select towns in the Hospital of Central Connecticut Service Area:

Diabetes: Age-Adjusted Mortality
(By Select Towns in the HOCC Service Area, 2006-2010)



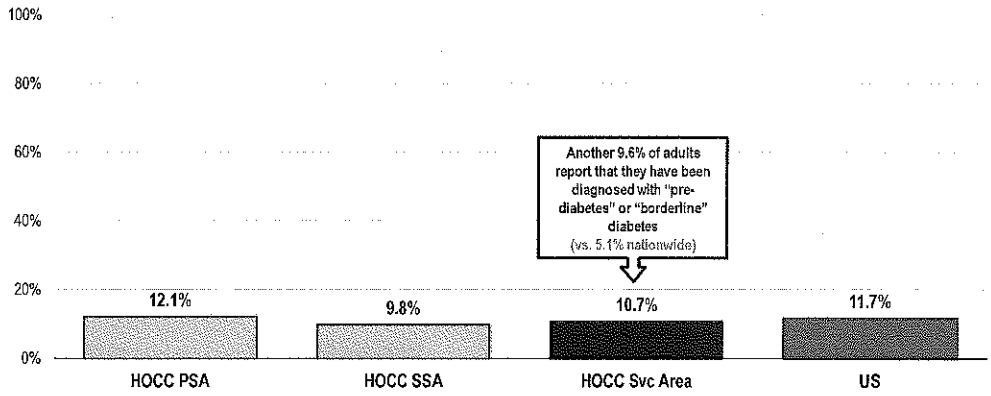
Source: • Connecticut Department of Public Health

Prevalence of Diabetes

"Have you ever been told by a doctor that you have diabetes? (If female, add: Not counting diabetes only occurring during pregnancy?)"

"(If female, add: Other than during pregnancy,) Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes?"

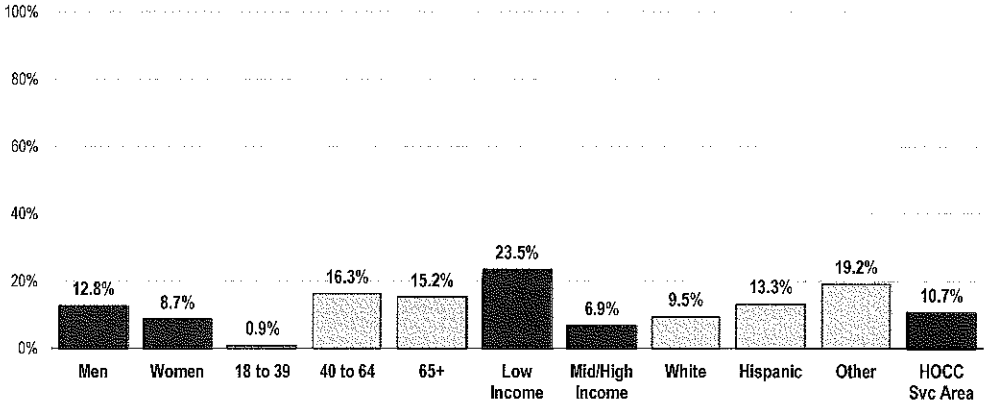
Prevalence of Diabetes



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Local and national data exclude gestation diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(HOCC Service Area, 2015)

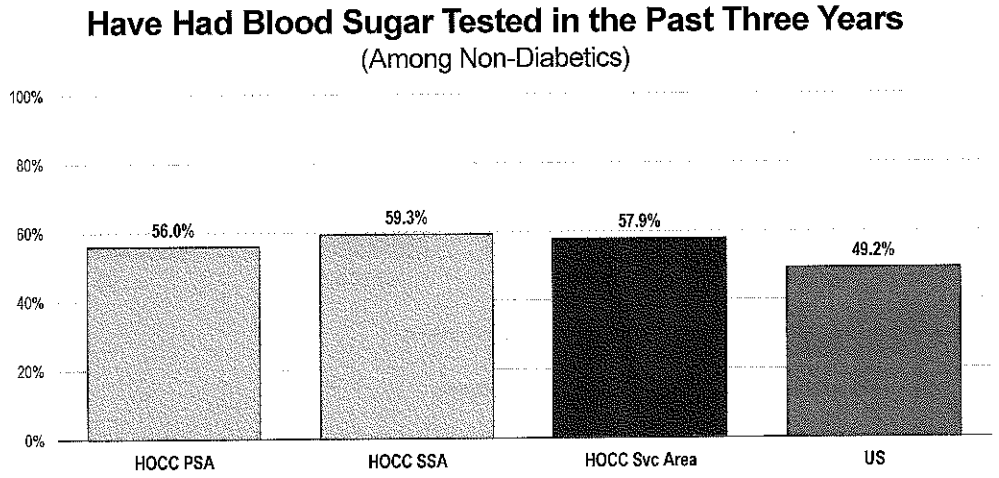


Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestation diabetes (occurring only during pregnancy).

Diabetes Testing

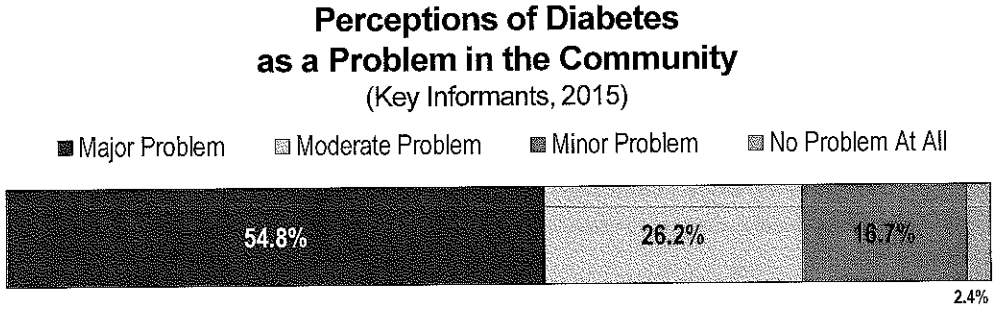
"Have you had a test for high blood sugar or diabetes within the past three years?"



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Challenges

Among those rating this issue as a "major problem," the biggest challenges for people with diabetes are seen as:

Disease Management

> *Management. – Public Health Expert*
>
> *Disease management. – Public Health Expert*
>
> *Staying on top of their medication management and practicing good nutrition. – Health Provider (Non-Physician)*
>
> *The biggest challenge is being able to afford diabetic medication, having access to healthier food alternatives and the biggest challenge is changing eating habits. – Health Provider (Non-Physician)*
>
> *Being diagnosed in the first place, then once diagnosed finding a primary care physician to help with ongoing care, then being able to afford medications then changing lifestyle to become healthier. – Health Provider (Non-Physician)*
>
> *Prevention and access to treatment. – Physician*

At-Risk Populations

> *Diabetes is an issue that is affecting the Latino community at an alarming rate. It is not just about education my community on what to eat and so on, but it is also about educating the community on how certain foods will affect diabetes and what are the best approaches. Adherence to meds is another factor, if a patient truly understands what these meds are for, side effects, etc. They will make better informed decisions. – Social Services Representative*
>
> *Latinos have higher diabetes incidence and more complications and mortality due to diabetes. A randomized controlled trial conducted by Hartford Hosp., Yale Univ. and HHC provided in-home peer counseling to Latinos patients of HH with diabetes. Findings included: a) this intensive service model, 17 home visits in one year decreased the HbA1 (b) down one full point compared to .4 in the control group, and the difference was sustained six months post-intervention and c) gaps in care, care coordination and cultural competence identified by the hospital's clinical team that partnered in the study - including the need for in-hospital care coordination and cultural competence training. The peer counseling service ended when the study ended. HHC is pursuing ways to sustain funding for community health workers through the affordable care act, including specialized, intensive models like this one, that ultimately improve health and save health care dollars. – Social Services Representative*
>
> *High risk population with socio-economic barriers to wellness and nutrition strategies to prevent or mitigate diabetes. – Community/Business Leader*
>
> *A serious problem in communities of color, and may grow in the general population with high obesity rate. – Community/Business Leader*

Diabetes Education & Prevention

> *Awareness to prevent onset of diabetes. – Public Health Expert*
>
> *Diabetic patients with care GPAs for recommended services such as Optometry, Podiatry and Nutrition. Lacking appropriate education. – Health Provider (Non-Physician)*
>
> *There are several challenge of people with diabetes including diabetes prevention, education and management. – Social Services Representative*
>
> *Besides access to endocrinologists, patient education and information appears to be rather lacking, especially information in Spanish and other languages other than English. – Physician*

Diet, Exercise & Weight

> *I think two of the biggest challenges are obtaining quality nutritious food and maintaining proper physical activity levels. – Health Provider (Non-Physician)*
>
> *Limited access to fresh fruit and vegetables. – Social Services Representative*
>
> *Healthy eating. It is expensive to eat healthy. – Social Services Representative*
>
> *Weight control. – Community/Business Leader*

Prevalence of Diabetes

> *There is a high prevalence of diabetes in Hartford. Further we know obesity is a struggle and a high percentage of the population is overweight. Hartford is a food desert and there are a number of barriers to accessing healthy food and exercising. – Community/Business Leader*
>
> *Studies/assessments have determined that to be the case. – Community/Business Leader*

Alzheimer's Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

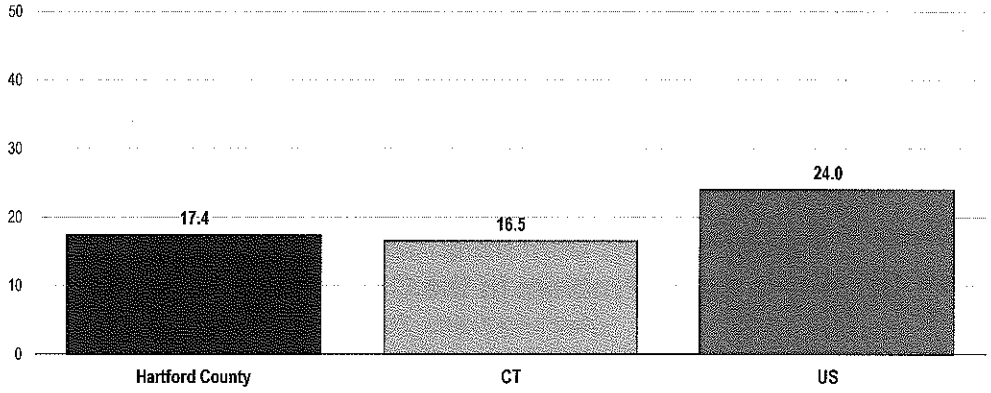
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality rates for the region and select towns are outlined in the following charts.

Alzheimer's Disease: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

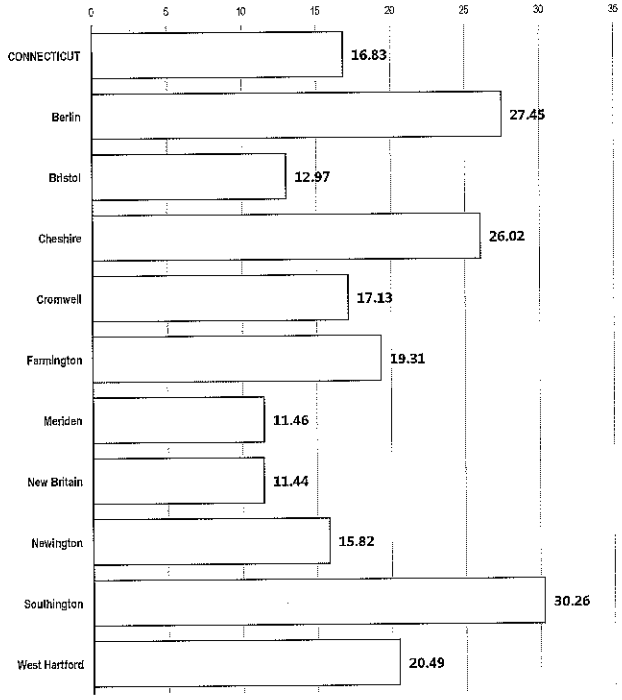


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Alzheimer's Disease: Age-Adjusted Mortality

(By Select Towns in the HOCC Service Area, 2006-2010)



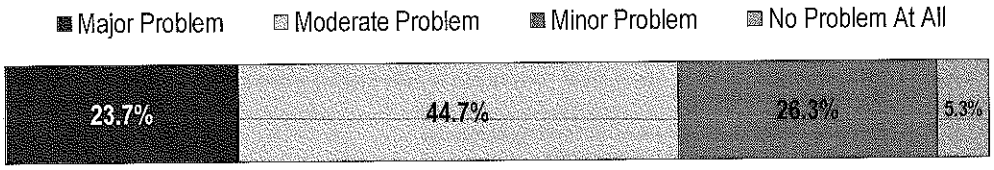
Source: • Connecticut Department of Public Health

Key Informant Input: Dementias, Including Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementias, Including Alzheimer's Disease* as a problem in the community:

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Support for Patients & Caregivers

> *Lack of support for caregivers. Financial and emotional burden on families with little to no available support. – Public Health Expert*
>
> *Insufficient community support for persons with dementia, Alzheimer's. – Public Health Expert*

> *Limited support, evaluation process and treatment regimens varied and not standardized. – Health Provider (Non-Physician)*
>
> *Unsure of the prevalence, but the stress on families, especially when onset is rapid, can be debilitating. This is not solely about the individual. – Health Provider (Non-Physician)*

Low-Income Seniors

> *Many low-income seniors do not have adequate support or advocacy to deal with these challenges. – Community/Business Leader*
>
> *There is only an option for expensive care nothing exits for those who cannot afford it. – Health Provider (Non-Physician)*

Lack of Geriatricians

> *Connecticut has a shortage or rather limited number of geriatricians and much of the care is limited to home care and nursing home facilities. There are simply not that many independently practicing geriatricians because the reimbursement is simply not sufficient. – Physician*

Kidney Disease

About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

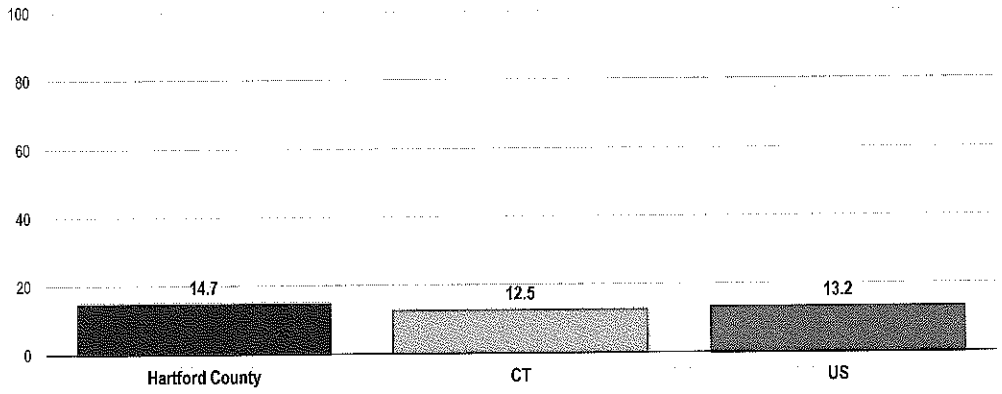
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following charts.

Kidney Disease: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

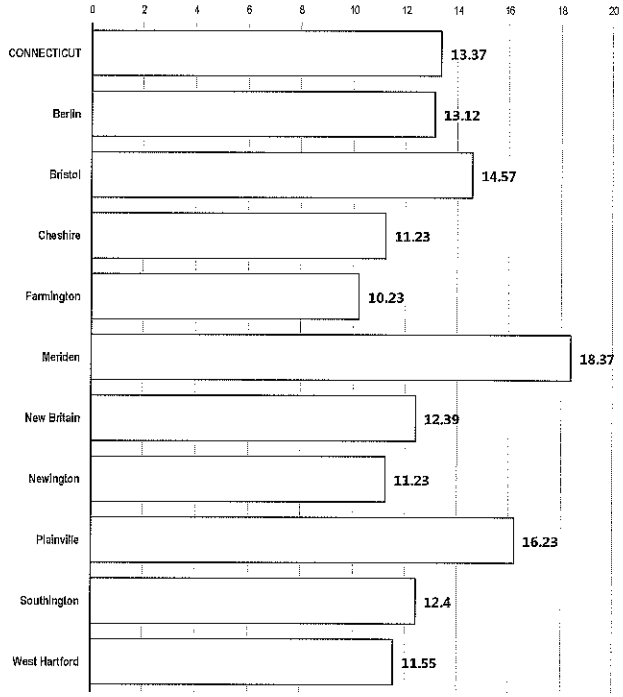


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Kidney Disease: Age-Adjusted Mortality

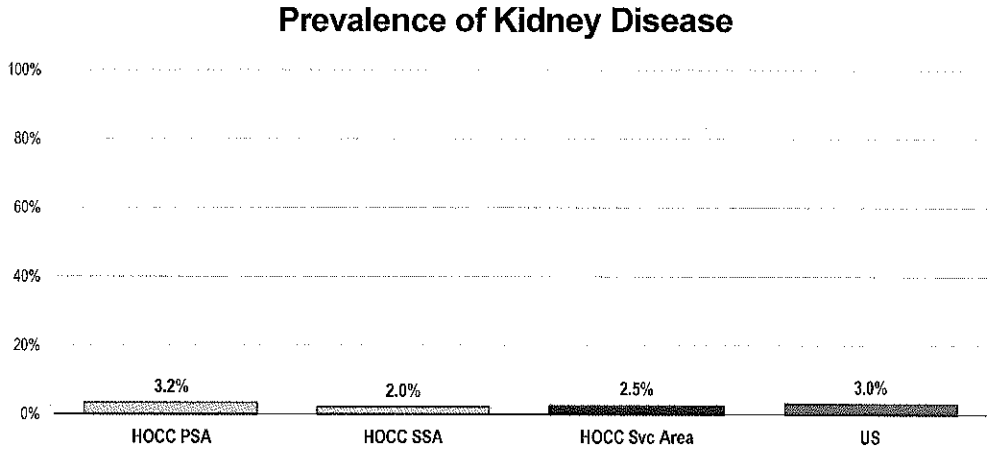
(By Select Towns in the HOCC Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

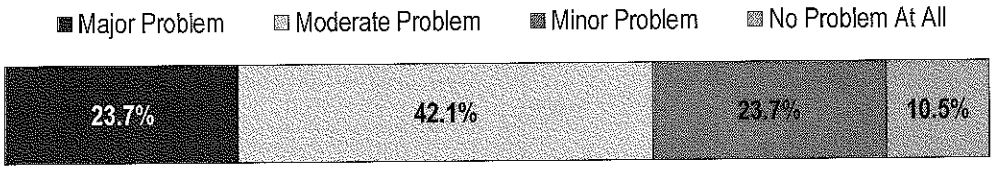


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Chronic Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Chronic Kidney Disease* as a problem in the community:

Perceptions of Chronic Kidney Disease as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Related to Other Serious Health Issues

> *Results from a number of other prevalent conditions. – Physician*
>
> *It leads to other serious ailments that can be life threatening. – Health Provider (Non-Physician)*
>
> *There are many different factors that leads to chronic Kidney disease such as diabetes or hypertension. – Social Services Representative*

African American Community

> *Chronic kidney disease is often suffered by members of the African American descent, which is the population group that makes up the majority of the Hartford area. This is due to the lack of proper diet, medical management of hypertension and diabetes, all of which are greatly suffered by members of this community as well. – Health Provider (Non-Physician)*
>
> *African Americans are three times more likely to experience kidney failure than whites. – Health Provider (Non-Physician)*

Prevalence of Kidney Disease

> *Studies/assessments have determined that to be the case. – Community/Business Leader*

Lack of Nephrologists

> *There are very few actively clinically practicing nephrologists in Connecticut that are not tied to academic medical centers, it makes access to ESRD care very trying for patients in the outlying areas. – Physician*

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

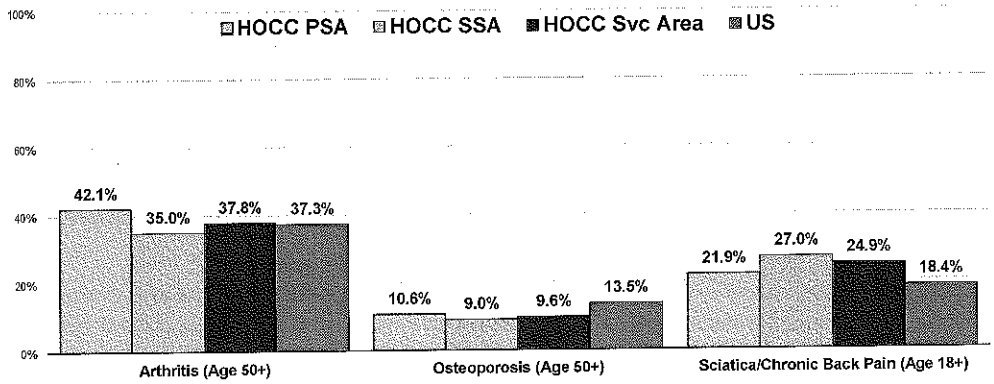
"Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?" (Reported below among only those age 50+.)

"Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?" (Reported below among only those age 50+.)

"Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?" (Reported below among all adults age 18+.)

See also *Activity Limitations* in the General Health Status section of this report.

Prevalence of Arthritis, Osteoporosis & Chronic Back Conditions



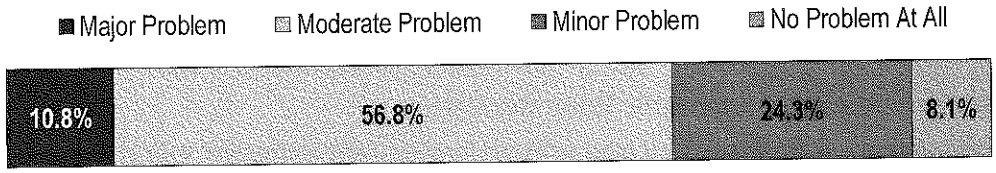
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 29, 139, 140]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The following chart outlines key informants' perceptions of the severity of *Arthritis, Osteoporosis & Chronic Back Conditions* as a problem in the community:

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Prevalence

> *Is a common identified medical problem among our patients. – Health Provider (Non-Physician)*
>
> *Common chronic condition leading to pain and disability. – Physician*

Lack of Rheumatologists

> *There are fewer and fewer available Rheumatologists who are focusing full time on rheumatoid related conditions. Also, there are fewer clinically practicing orthopedists who are not hospital employed and who have available office hours. – Physician*

Vision & Hearing Impairment

Vision Trouble

About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

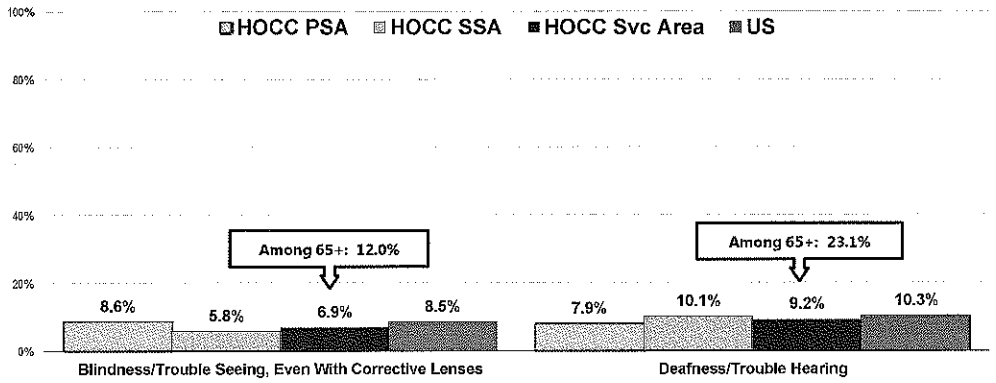
- Healthy People 2020 (www.healthypeople.gov)

"Would you please tell me if you have ever suffered from or been diagnosed with blindness or trouble seeing, even when wearing glasses?"

"Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?"

- Note the higher prevalence among older adults (age 65+).

Prevalence of Vision & Hearing Difficulty



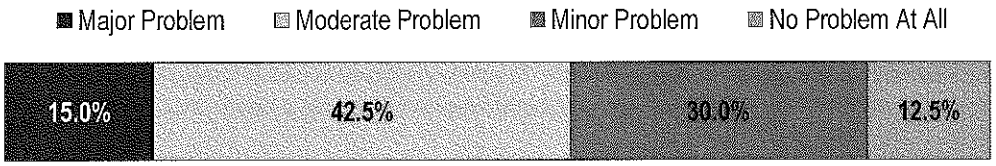
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 26-27]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Vision & Hearing

The following chart outlines key informants' perceptions of the severity of *Vision & Hearing* as a problem in the community:

Perceptions of Hearing and Vision as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Cost of Services

> *Cost of hearing aids and the cost of glasses but also the availability of specialized ophthalmologic are limited, especially for Pediatrics. – Physician*
>
> *The number of providers accepting Medicare/Medicaid is limited, especially in the rural areas my agency serves. – Health Provider (Non-Physician)*

Growing Aging Population

> *There is growing aging population that these issues are starting to become a concern. – Social*

Services Representative

Prevalence

High incidence of diabetes, cardiovascular disease with microvascular complications, including retinopathy. Macular degeneration is prevalent and impacts one's quality of life and at times safety with regard to discharge disposition. – Health Provider (Non-Physician)

Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by $9.9 billion.
- Saves $33.4 billion in indirect costs.

- Healthy People 2020 (www.healthypeople.gov)

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

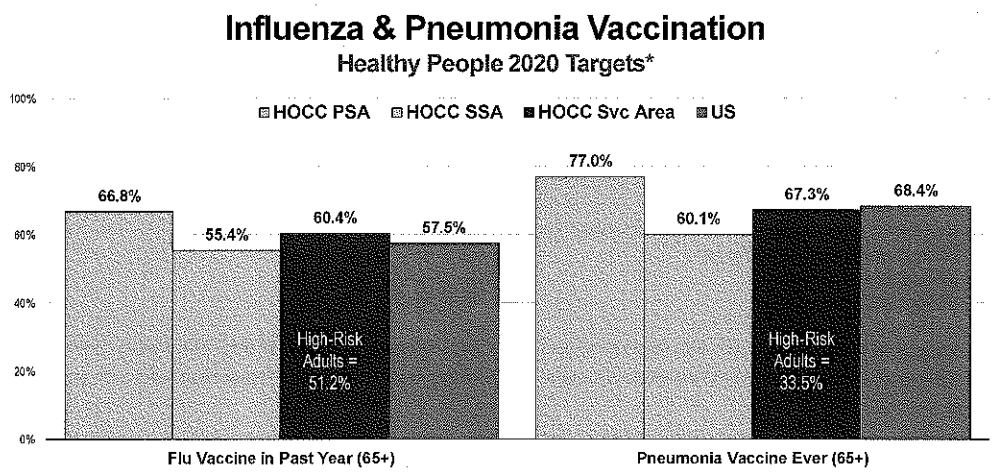
Flu Vaccinations

"There are two ways to get the seasonal flu vaccine, one is a shot in the arm and the other is a spray, mist, or drop in the nose called FluMist®. During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?"

"A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?"

Chart columns below show these findings among those age 65+. Percentages for "high-risk" adults age 18-64 in the Hospital of Central Connecticut Service Area are also shown; here, "high-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.)

- Note also the Healthy People 2020 targets.



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 141-144]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives HD-12.6, 12.7, 13.1, 13.2]

Notes:
- Asked of all respondents.
- *The Healthy People 2020 target for influenza vaccination is 70% for all populations; the targets for pneumonia vaccination are 90% for 65+ and 60% for other high-risk adults.

HIV

About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

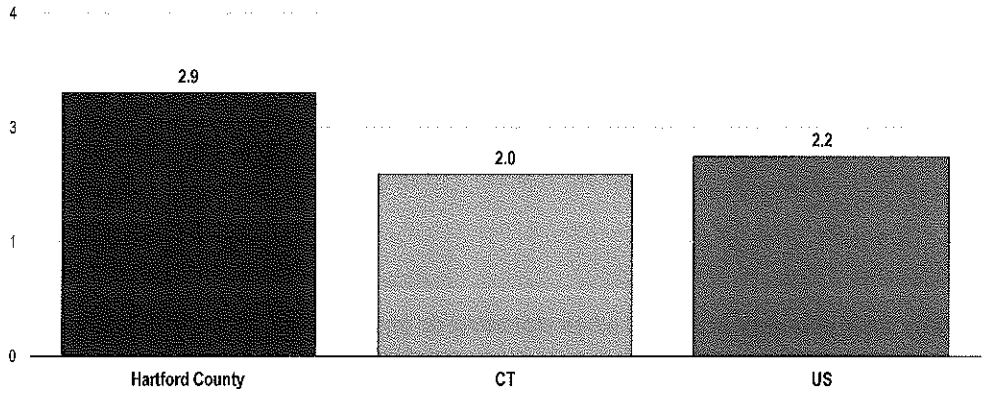
HIV/AIDS Deaths

The following chart outlines age-adjusted mortality rates for the area in comparison with state and national rates.

HIV/AIDS: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 3.3 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

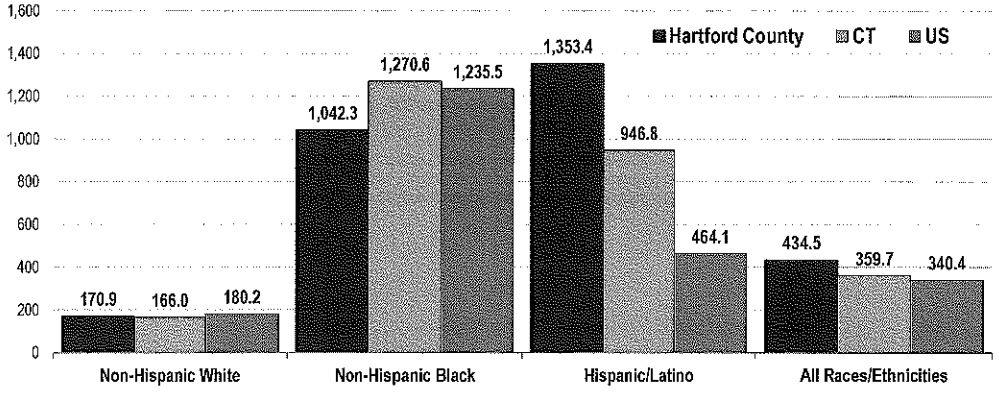
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

HIV Prevalence

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.

HIV Prevalence Rate by Race/Ethnicity

(Prevalence Rate of HIV per 100,000 Population, 2010)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

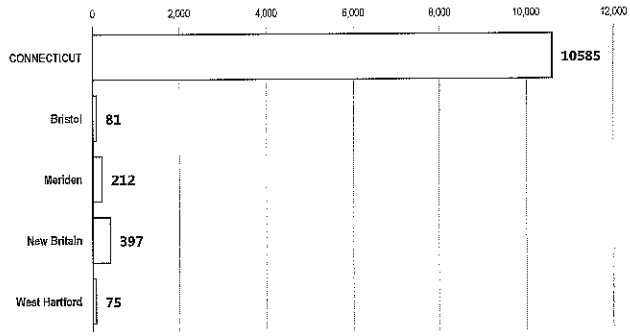
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Persons Living With HIV

The following chart shows the number of persons living with HIV in select towns in the Hospital of Central Connecticut Service Area.

Persons Living With HIV (PLWH)
(By Select Towns in the HOCC Service Area, 2007-2011)

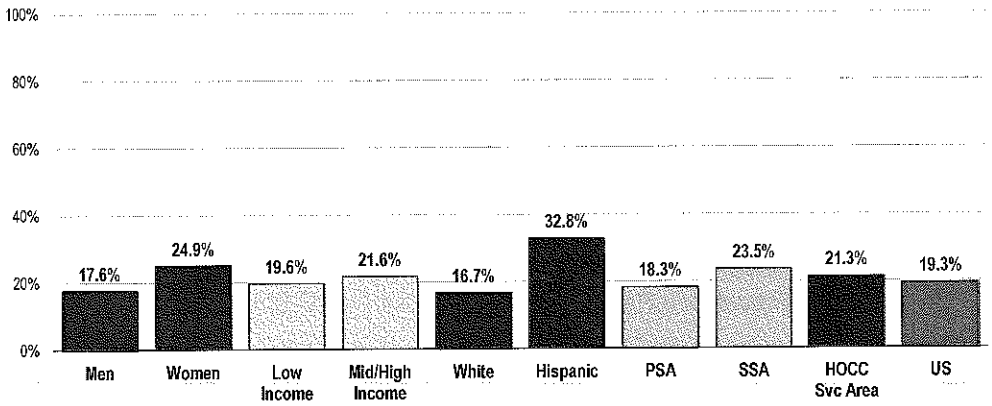
Source: • Connecticut Department of Public Health



HIV Testing

"Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?" (Reported in the following chart only among adults age 18 to 44.)

Tested for HIV in the Past Year
(Among Adults Age 18-44)



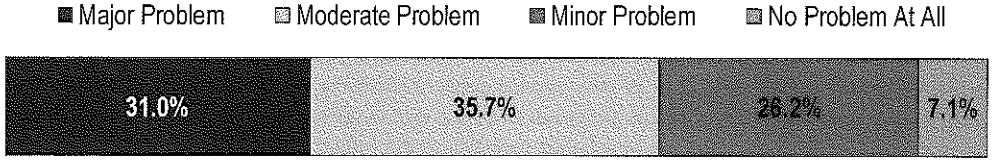
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 145]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 18 to 44.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: HIV

The following chart outlines key informants' perceptions of the severity of *HIV* as a problem in the community:

Perceptions of HIV/AIDS as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

At-Risk Populations

> *Men who have sex with men (MSM) is the population with significantly increasing rate of HIV. There is not enough prevention education. – Social Services Representative*
>
> *There are growing case of HIV/AIDS in women of color and the senior population. This is due a number of reasons but mostly lack of education and reinforce knowledge of sexual. HIV/AIDS is result of not practicing safe sex. – Social Services Representative*
>
> *As an HIV/AIDS organization, we are still engaging and diagnosing new cases. People are still thinking that it is not a major problem, but our young Latino and African American community is coming back infected. – Social Services Representative*
>
> *While HIV/AIDS incidence overall has declined, it affects Latino communities disproportionately, especially in the northeast/Connecticut. Latinos are more likely to be tested after the infection has progressed beyond the early stages of the disease. – Social Services Representative*
>
> *Studies/assessments have determined that to be the case, particularly among the black community. – Community/Business Leader*

Substance Abuse

> *HIV/AIDS ties directly in with substance abuse which is also a major problem in the Hartford area. Promiscuous activity and unprotected sex. – Health Provider (Non-Physician)*
>
> *High drug use. – Health Provider (Non-Physician)*
>
> *Lack of education. High substance abuse rates, risky behaviors. – Public Health Expert*

Prevalence of HIV/AIDS

> *There is a high prevalence of HIV/AIDS in Hartford compared to other CT communities. There is stigma associated with this illness and beliefs that residents hold that creates fear and keeps them from getting testing and treatment. – Community/Business Leader*
>
> *Data show. – Physician*

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons "linked" by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

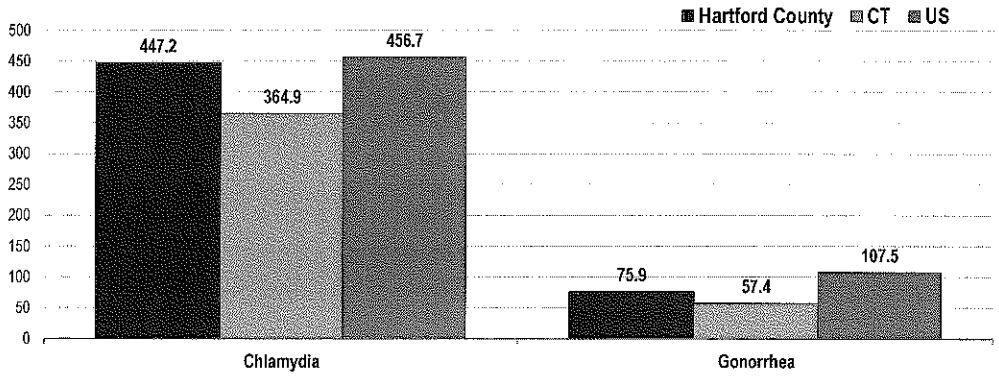
Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia don't know it since the disease often has no symptoms.

Gonorrhea. Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following charts outline local incidence for these STDs.

Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2012)

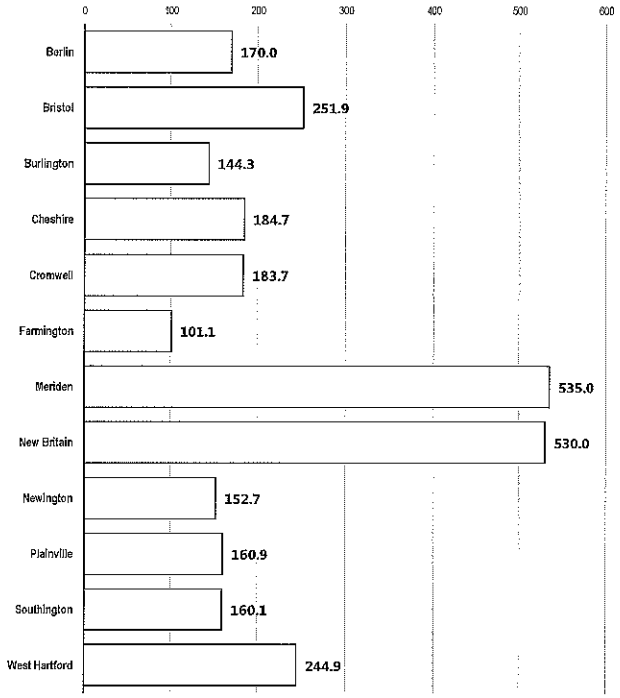


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2012.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Chlamydia Incidence Rate per 100,000

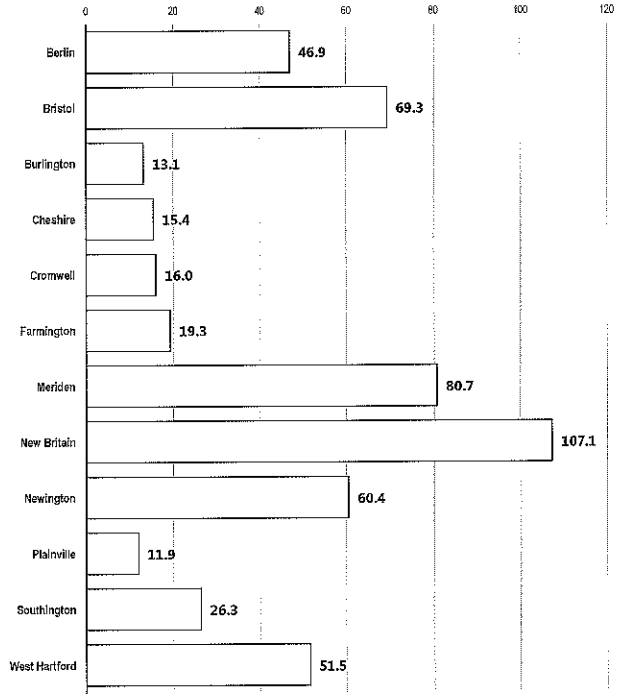
(By Select Towns in the HOCC Service Area, 2013)



Source:
- Connecticut Department of Public Health

Gonorrhea Incidence Rate per 100,000

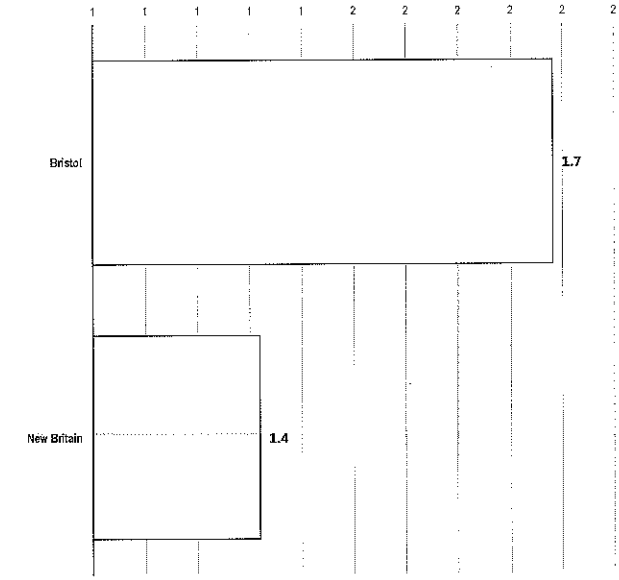
(By Select Towns in the HOCC Service Area, 2013)



Source: • Connecticut Department of Public Health

Primary & Secondary Syphilis Incidence Rate per 100,000

(By Select Towns in the HOCC Service Area, 2013)



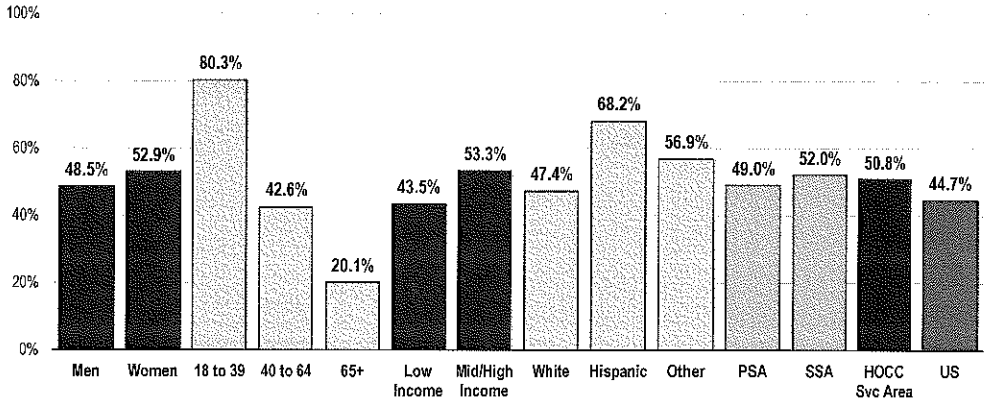
Source: • Connecticut Department of Public Health

Hepatitis B Vaccination

"To be vaccinated against hepatitis B, a series of three shots must be administered, usually at least one month between shots. Have you completed a hepatitis B vaccination series?"

Have Completed the Hepatitis B Vaccination Series

(HOCC Service Area, 2015)



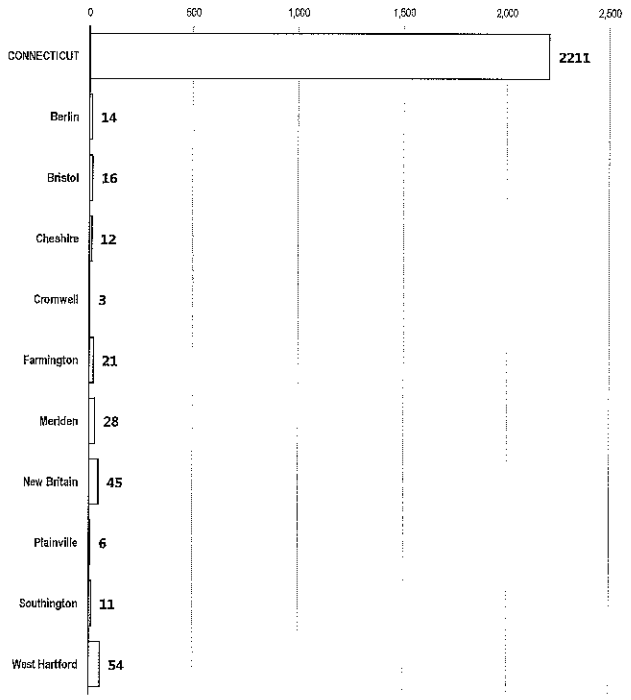
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Numbers of cases of hepatitis B for select towns in the service area are shown below.

Cases of Chronic Hepatitis B

(By Select Towns in the HOCC Service Area, 2007-2011)



Source:
- Connecticut Department of Public Health

Safe Sexual Practices

Sexual Partners

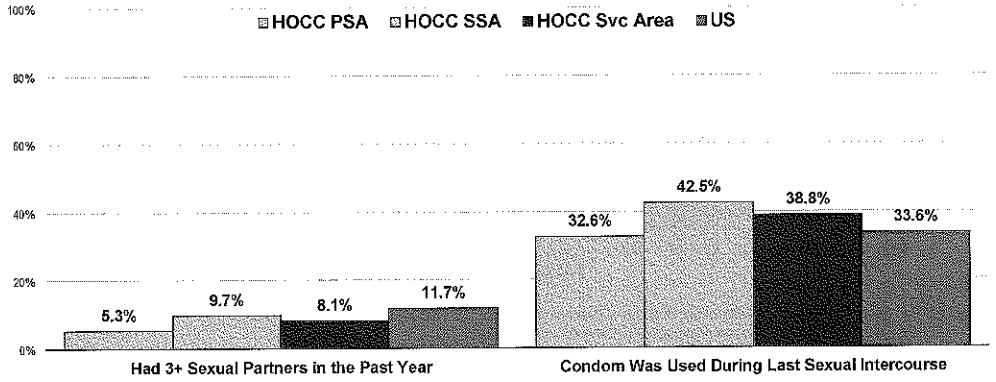
"During the past 12 months, with how many people have you had sexual intercourse?"

"Was a condom used the last time you had sexual intercourse?"

Each of these is reported below only among adults who are unmarried and between the ages of 18 and 64.

Safe Sexual Practices

(Among Unmarried Adults Age 18-64; HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 86-87]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

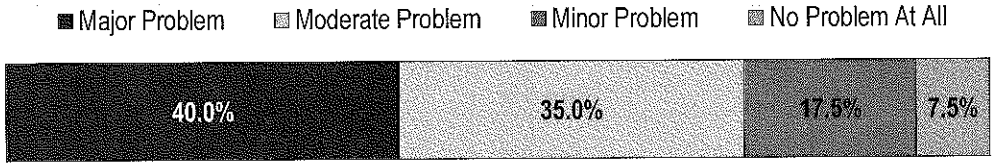
Notes:
- Asked of all unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

The following chart outlines key informants' perceptions of the severity of *Sexually Transmitted Diseases* as a problem in the community:

Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2015)



Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

At-Risk Populations

> *CT has a high incidence of STI's, Gonorrhea, Chlamydia and Syphilis are in high numbers in my community, especially within the young MSM community and other youth. – Social Services Representative*
>
> *Gonorrhea, chlamydia and syphilis have higher incidence rates in Hartford than elsewhere in the state and rates are disproportionately high among Latinos and Blacks. There has been a major increase in prevalence of syphilis. – Social Services Representative*
>
> *Men who have sex with men account for the vast majority of syphilis cases in CT. Some are co-infected with HIV. They also test positive for other STD's. – Social Services Representative*
>
> *Contributing factors include low income young pregnant teens. Unable to afford the cost of protection. – Health Provider (Non-Physician)*

Prevalence of STDs

> *Hartford has high rates/100K of STDs, including Chlamydia, Gonorrhea Hepatitis C, etc. compared to most other communities in CT. Others of the larger cities have similar rates to Hartford. – Community/Business Leader*
>
> *We have seen a slow but steady increase in Chlamydia over the last few years. – Community/Business Leader*

Education

> *People need more educational services on practicing safe sex. – Health Provider (Non-Physician)*

Risky Behaviors

> *Misinformation. Substance abuse leading to risky sexual behaviors. Mental illness leading to risky sexual behaviors. Lack of education. – Public Health Expert*

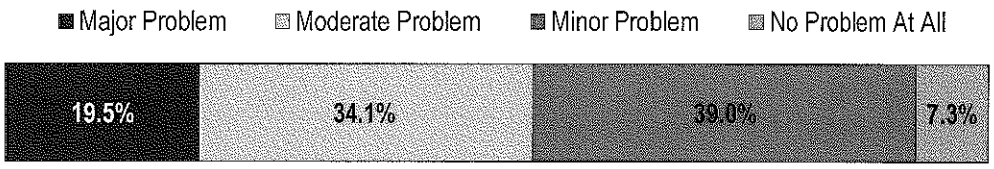
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants' perceptions of the severity of *Immunization & Infectious Diseases* as a problem in the community:

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Education & Access

> *Lack of education. Poor life management skills. Lack of access to primary care. – Public Health Expert*
>
> *Preventable diseases. – Physician*
>
> *Can affect all sorts of physical ramifications if not treated. – Health Provider (Non-Physician)*

Lack of Resources

> *We don't have any resources that I know of. I have heard of people needing to travel to UConn Health Center for treatment. – Community/Business Leader*

Births

Prenatal Care

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 (www.healthypeople.gov)

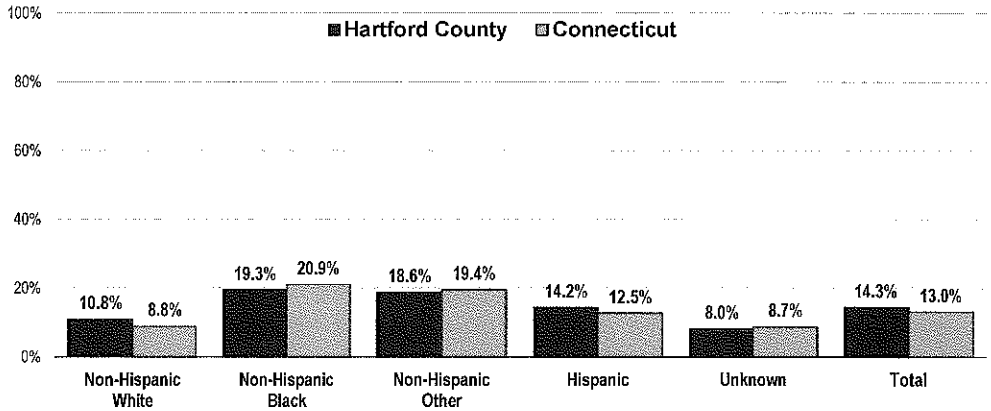
Early and continuous prenatal care is the best assurance of infant health. Receipt of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following charts.

- Note the Healthy People 2020 target.

Lack of Prenatal Care in the First Trimester

(By Race; Percentage of Live Births, 2011)

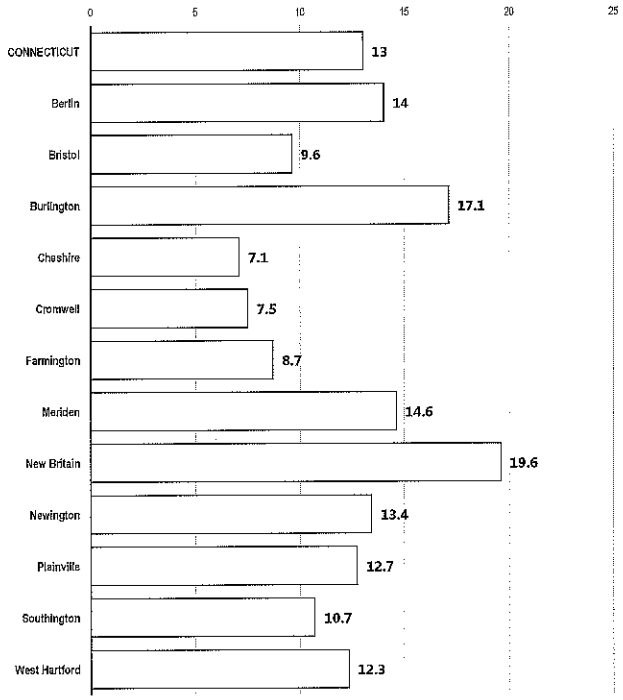
Healthy People 2020 Target = 22.1% or Lower



Sources:
- Connecticut Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

Percent of Births With Late or No Prenatal Care
(By Select Towns in the HOCC Service Area, 2011)



Source: • Connecticut Department of Public Health

Birth Outcomes & Risks

Low-Weight Births

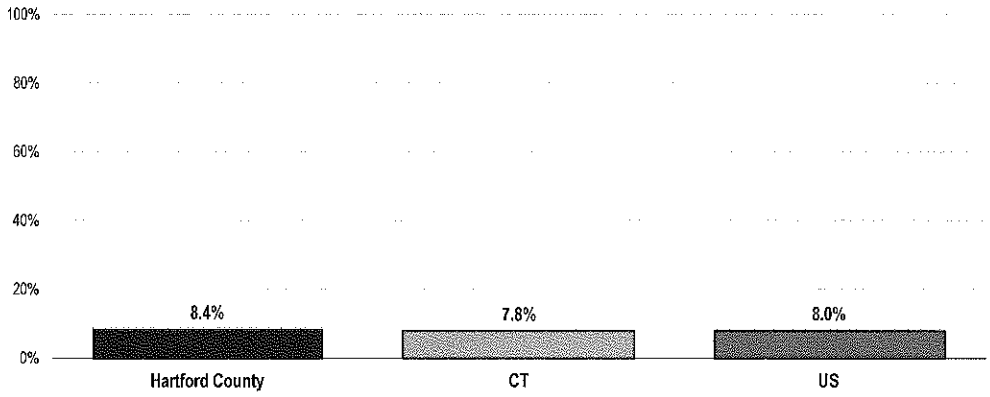
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. Births of low-weight infants are described in the following charts.

- Note the Healthy People 2020 target.

Low-Weight Births

(Percent of Live Births, 2011-2013)

Healthy People 2020 Target = 7.8% or Lower

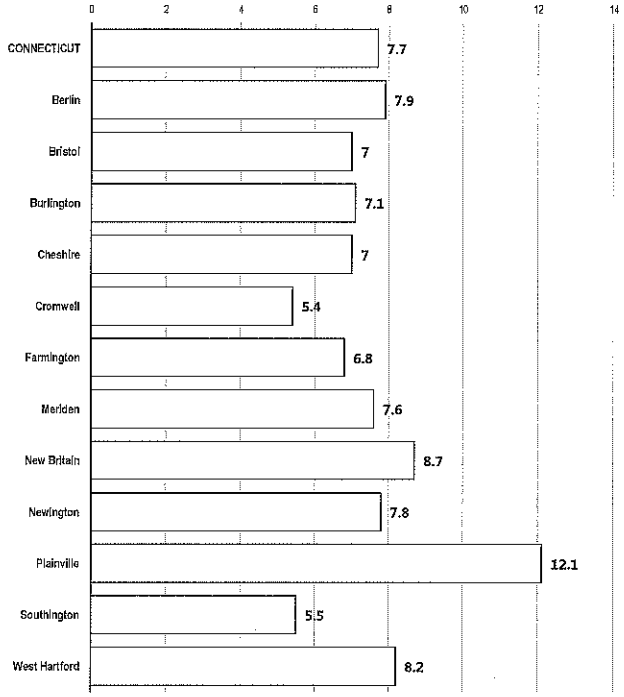


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
- Retrieved February 2015 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Percent of Births With Low Birthweight

(By Select Towns in the HOCC Service Area, 2011)



Source:
- Connecticut Department of Public Health

Infant Mortality

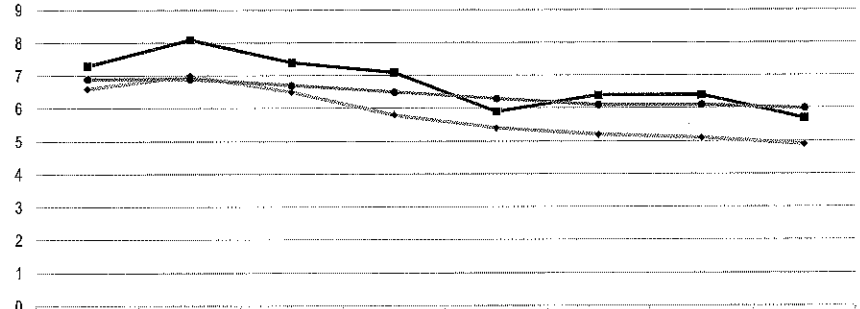
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following charts.

- Note the Healthy People 2020 target.

Infant Mortality Trends

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2020 Target = 6.0 or Lower



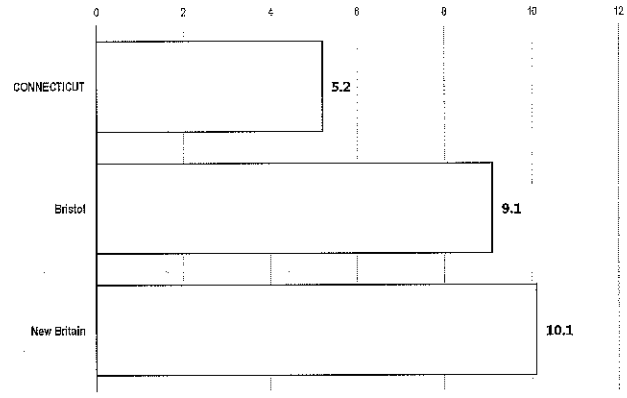
	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Hartford County	7.3	8.1	7.4	7.1	5.9	6.4	6.4	5.7
Connecticut	6.6	7.0	6.5	5.8	5.4	5.2	5.1	4.9
United States	6.9	6.9	6.7	6.5	6.3	6.1	6.1	6.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Infant Deaths per 1,000 Live Births

(By Select Towns in the HOCC Service Area, 2011)



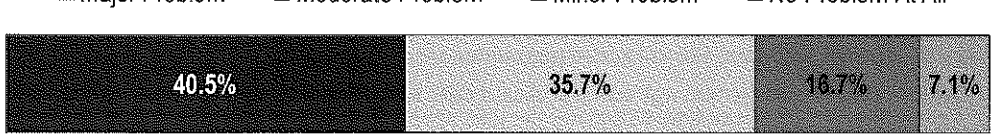
Source:
- Connecticut Department of Public Health

Key Informant Input: Infant & Child Health

The following chart outlines key informants' perceptions of the severity of *Infant & Child Health* as a problem in the community:

Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Barriers to Access to Care

> *While there have been major improvements in immunization rates, there continue to be barriers to adequate access to primary care. In addition, infant mortality rates are disproportionately high compared to state and national rates. Childhood overweight and obesity is a major problem, as is asthma. Breastfeeding incidence, duration and exclusivity rates have continued to improve, but have a long way to go citywide. – Social Services Representative*
>
> *Families do not have the funds to adequately take care of children. – Health Provider (Non-Physician)*
>
> *This is really only tied to Medicaid where there are some problems with the number of pediatric specialists in Husky/Medicaid. – Physician*
>
> *Timely access and transportation are challenging for many families. Also, some parents and other caregivers are not informed about proper infant and child health. – Community/Business Leader*
>
> *Infants of uninsured moms often skip recommended required vaccines. Records of undocumented difficult to obtain. Lack of nutritional education for obese children. – Health Provider (Non-Physician)*

Prevalence of Child Health Concerns

> *There are a number of issues that seem to be on the rise, obesity, asthma, autism and behavioral challenges. – Health Provider (Non-Physician)*
>
> *High asthma rates continue to be a major health issue for our students/families. – Community/Business Leader*
>
> *Studies/assessments have determined that to be the case. – Community/Business Leader*
>
> *Learning, nutrition, infant mortality. – Physician*
>
> *Statistically the town of Manchester has seen a higher than state average in pregnancy and infant loss. – Public Health Expert*
>
> *Neglected children. Poor access to childcare. Lack of access to primary care. Immigrant population. Food insecurity. – Public Health Expert*

Family Planning

Births to Teen Mothers

About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

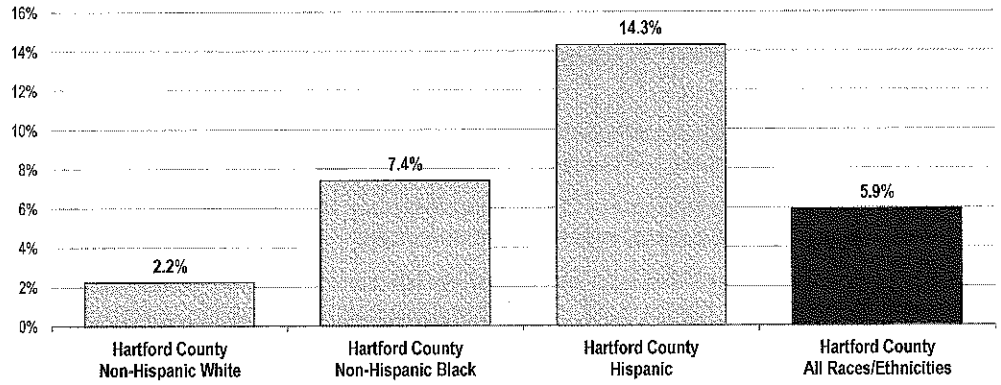
Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

The following charts describe local teen births.

Births to Teens

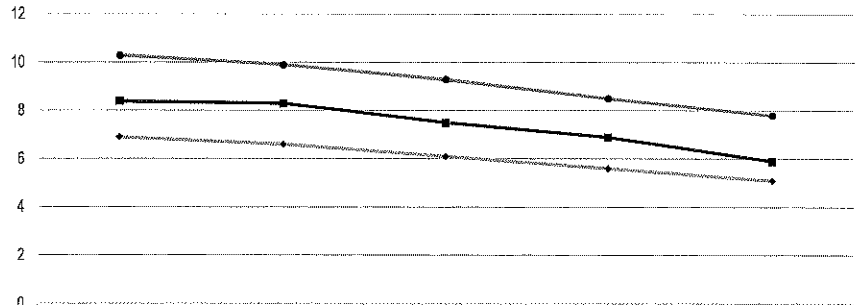
(Percent of Live Births to Women Under Age 20, 2011-2013)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Birth to Teens

(Percent of Live Births to Women Under Age 20, 2011-2013)

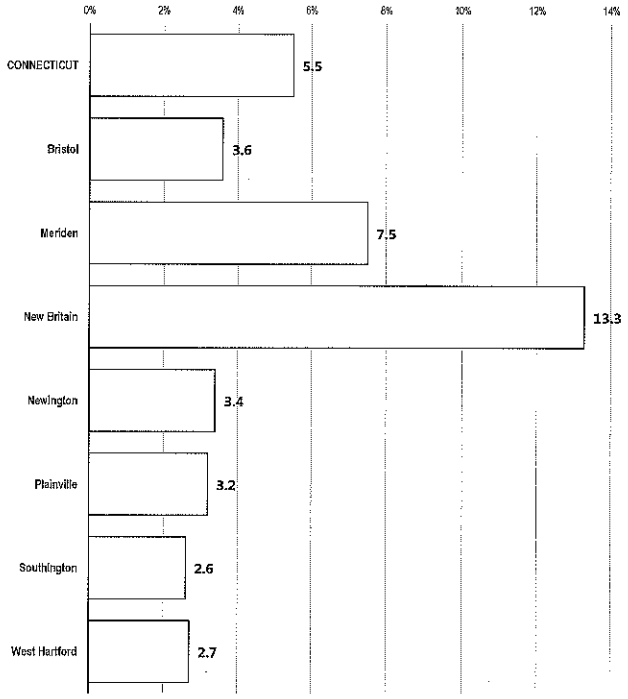


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Hartford County	8.4	8.3	7.5	6.9	5.9
Connecticut	6.9	6.6	6.1	5.6	5.1
United States	10.3	9.9	9.3	8.5	7.8

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Percent of Births to Mothers Under Age 20

(By Select Towns in the HOCC Service Area, 2011)

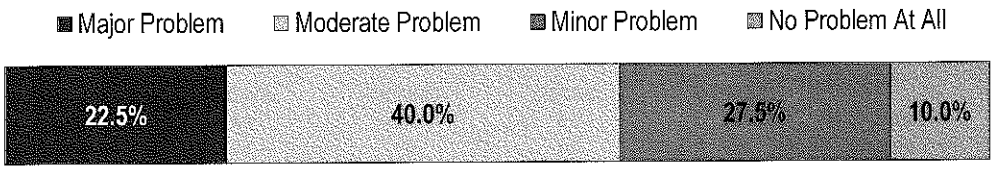


Source:
- Connecticut Department of Public Health

Key Informant Input: Family Planning

The following chart outlines key informants' perceptions of the severity of *Family Planning* as a problem in the community:

Perceptions of Family Planning as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Teen Births

> *High teen birth rate and low birth weight. – Physician*
>
> *Teen pregnancy continue to be an issue in our community. – Public Health Expert*
>
> *Teen pregnancy remains an issue in our school community. – Community/Business Leader*
>
> *I think many young woman have unplanned pregnancy and are not emotionally or practically prepared for parenthood. While many choose to have the baby, it is a struggle and greatly impacts their life choices (i.e. education, work, job training). In additional many young mothers have emotional struggles from their childhood and need support in working through them (i.e. counseling, parenting education, support groups). – Community/Business Leader*

Access to Care

> *Lack of easy access to long term birth control. – Social Services Representative*
>
> *It's not so much about family planning as about women having consistent access to pre-conception and pre-natal care regardless of income. – Community/Business Leader*

Education

> *Lack of education. Competing priorities. Lack of life skills. – Public Health Expert*

Lack of Primary Care Physicians

> *Our demographic is changing dramatically and wellness is critical. We have a shortage of primary care doctors. – Community/Business Leader*

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

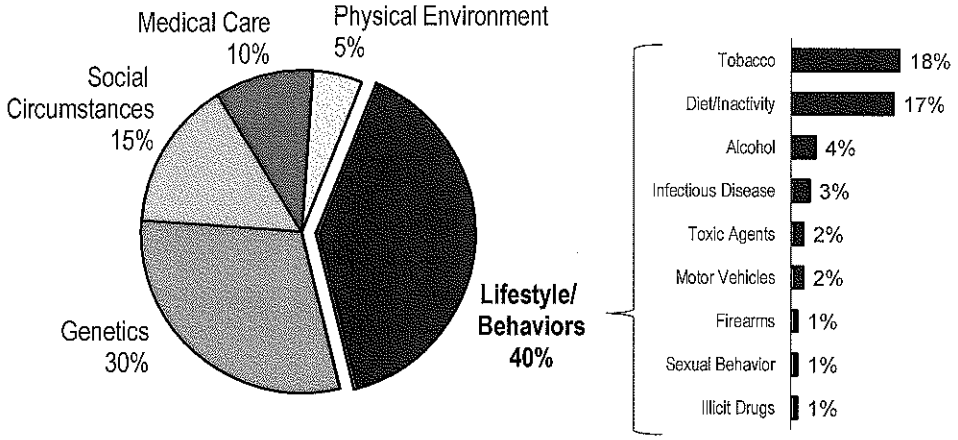
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States," JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States



Sources: • "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002.
"Actual Causes of Death in the United States": (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular Disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular Disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental Injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic Lung Disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health & Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88–1232.

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 (www.healthypeople.gov)

Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

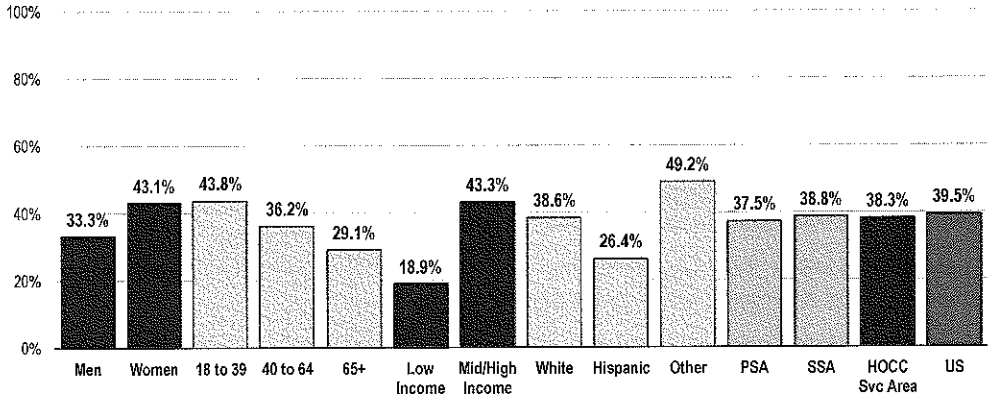
"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for adults at the respondent level. The proportion reporting having 5 or more servings per day is shown below.

Consume Five or More Servings of Fruits/Vegetables Per Day

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

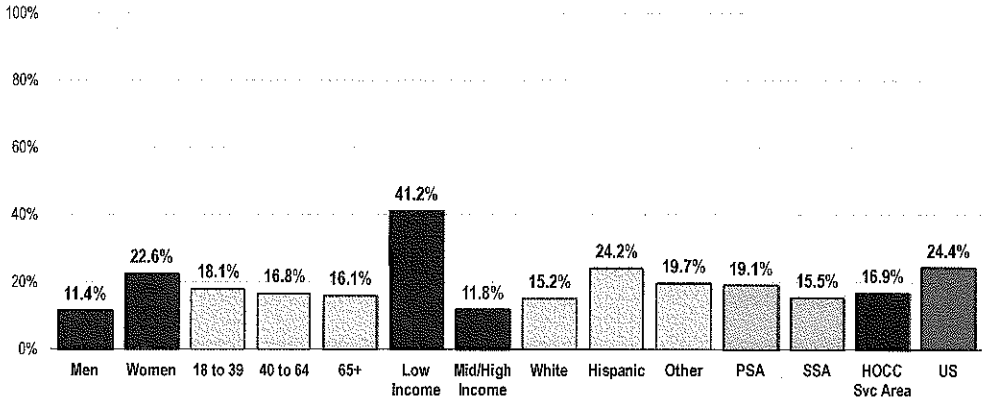
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

(HOCC Service Area, 2015)



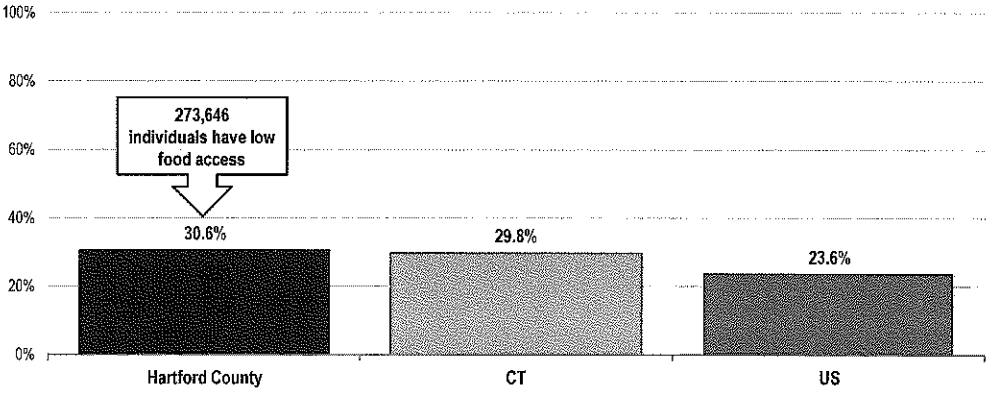
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. The chart for this indicator below is based on US Department of Agriculture data.

Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA): 2010.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)

Recommended Levels of Physical Activity

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

- 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Physical Activity Levels

Leisure-Time Physical Activity. Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

- Note the corresponding Healthy People 2020 target in the chart below.

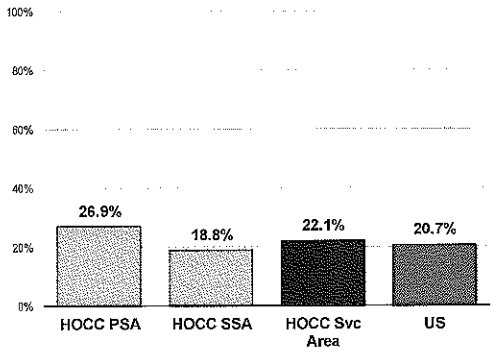
Meeting Physical Activity Recommendations. Meeting physical activity requirements means satisfying a minimum threshold of minutes per week with a combination of vigorous- and/or moderate-intensity physical activity (as determined from the questions below). These thresholds are described in the orange box above.

"Vigorous activities cause large increases in breathing or heart rate, while moderate activities cause small increases in breathing or heart rate. Now, thinking about when you are not working, how many days per week or per month do you do vigorous activities for at least 20 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing and heart rate?"

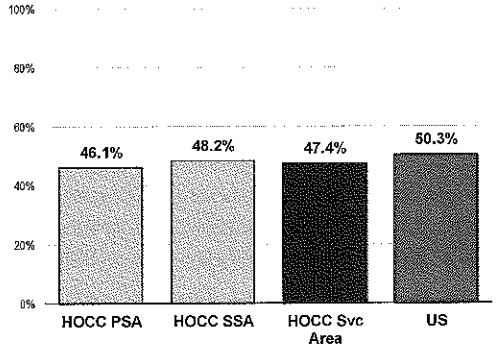
"And on how many days per week or per month do you do moderate activities for at least 30 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



Meets Physical Activity Recommendations



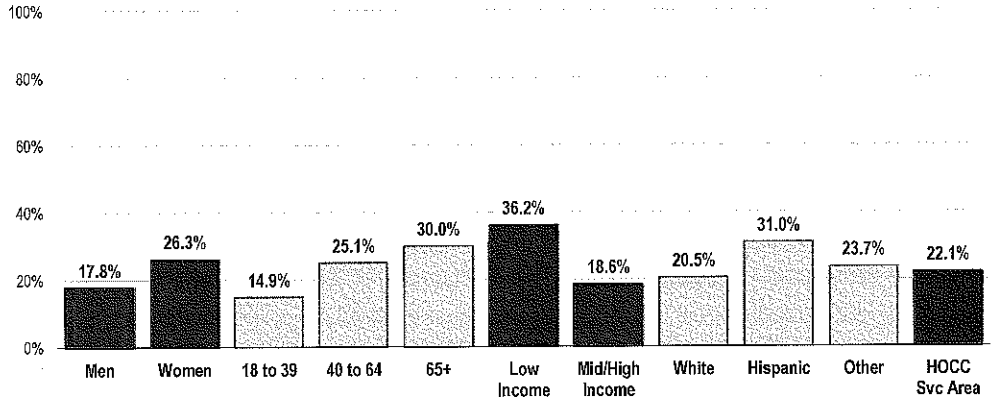
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 92, 147]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

No Leisure-Time Physical Activity in the Past Month

(HOCC Service Area, 2015)

Healthy People 2020 Target = 32.6% or Lower

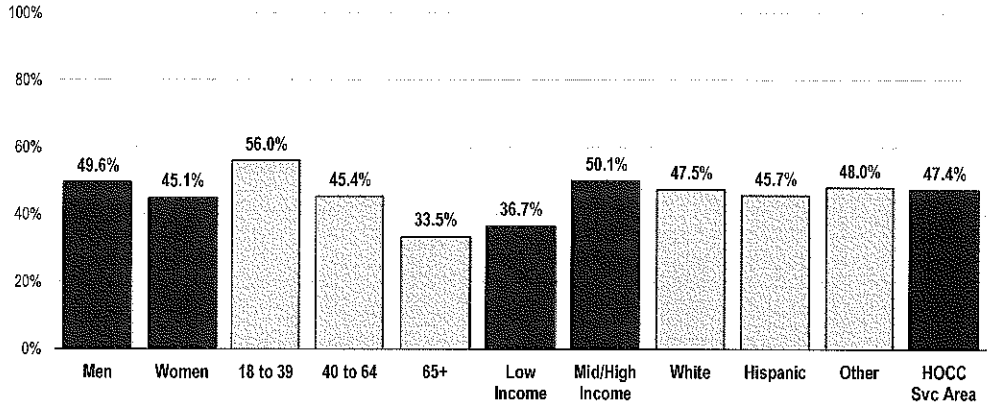


Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 92]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Meets Physical Activity Recommendations

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]

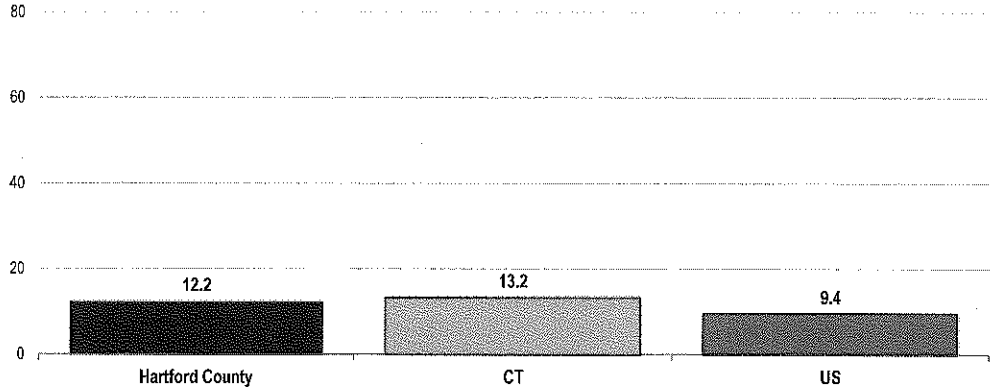
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Access to Physical Activity

Recreation & Fitness Facility Access. Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2012)



Sources:
- US Census Bureau, County Business Patterns: 2012. Additional data analysis by CARES.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

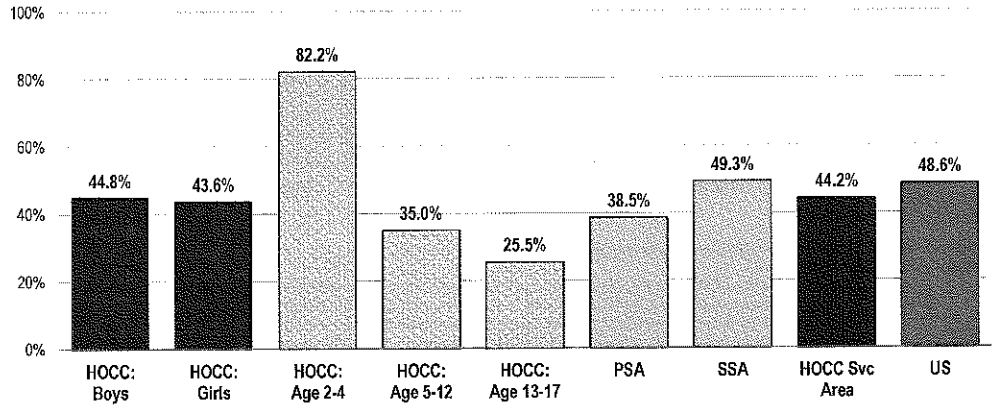
Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Children's Physical Activity

"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day

(Among Children Age 2-17)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight, not Obese	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

"About how much do you weigh without shoes?"

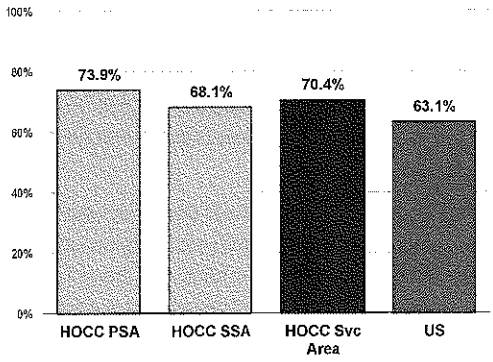
"About how tall are you without shoes?"

The survey questions above were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

- Note the Healthy People 2020 target for obesity.

Overweight or Obese

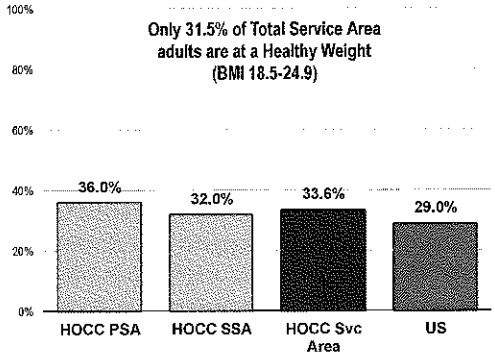
(Adults With a BMI of 25+)



Obese

(Adults With a BMI of 30+)

Healthy People 2020 Target = 30.5% or Lower



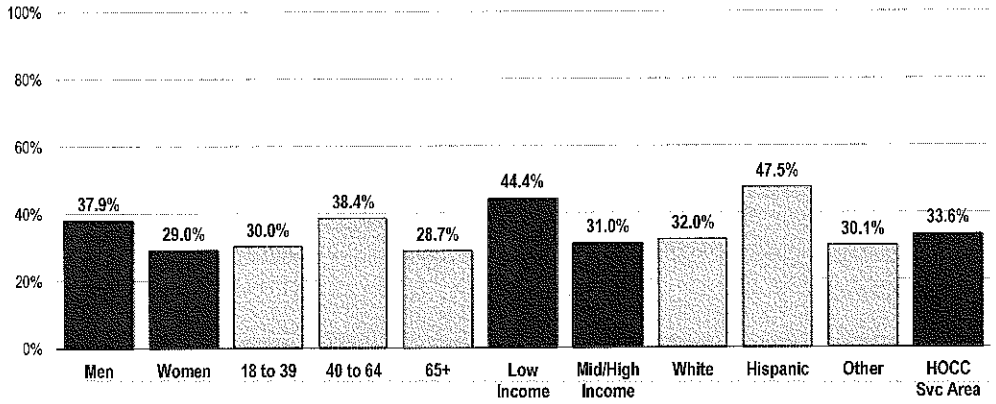
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; HOCC Service Area, 2015)

Healthy People 2020 Target = 30.5% or Lower



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Weight Control

About Maintaining a Healthy Weight

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

- Healthy People 2020 (www.healthypeople.gov)

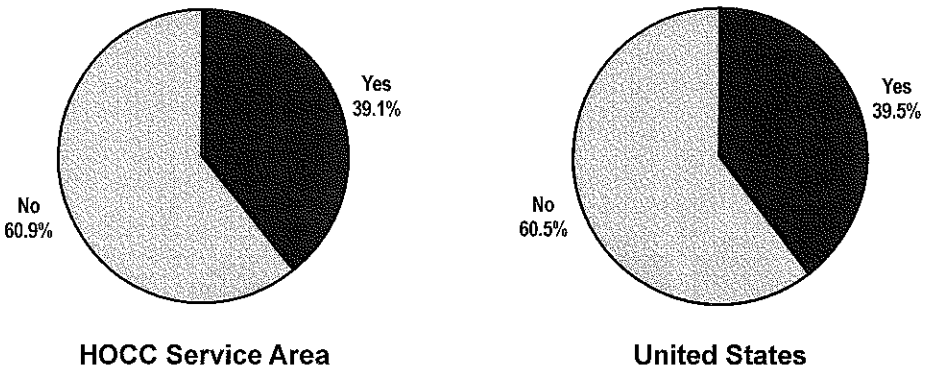
Weight Management. The following three questions were used to calculate the proportion of adults who are overweight or obese and who are using a combination of both diet and exercise in order to try to lose weight.

"Are you now trying to lose weight?"

"Are you eating either fewer calories or less fat to lose weight?"

"Are you using physical activity or exercise to lose weight?"

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity
(Among Overweight or Obese Respondents)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Reflects respondents who are overweight or obese based on reported heights and weights.

Childhood Overweight & Obesity

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

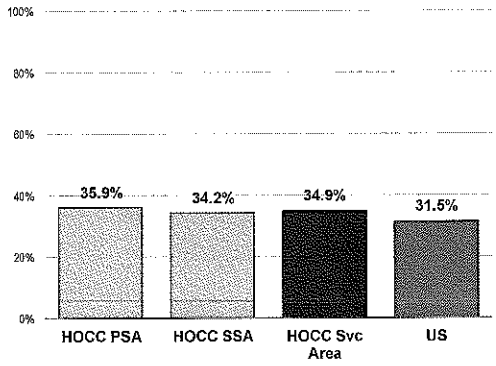
- Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

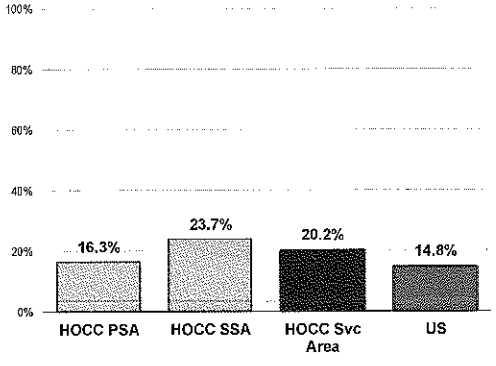
"How much does this child weigh without shoes?"

"About how tall is this child?"

Child Is Overweight
(Among Children Age 5-17; BMI 85th Percentile)



Child Is Obese
(Among Children Age 5-17; BMI 95th Percentile)
Healthy People 2020 Target = 14.5% or Lower



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Health Advice About Physical Activity & Exercise

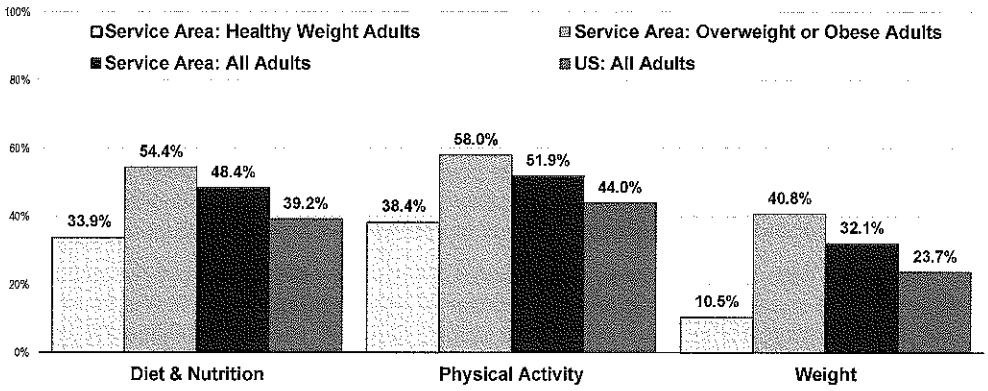
"During the past 12 months, has a doctor asked you about or given you advice regarding diet and nutrition?"

"During the past 12 months, has a doctor asked you about or given you advice regarding physical activity or exercise?"

"In the past 12 months, has a doctor, nurse or other health professional given you advice about your weight?"

The chart below details responses to these questions among the total sample of respondents, as well as responses segmented by weight classification based on calculated BMI.

Have Received Advice About _____ From a Physician, Nurse, or Other Health Professional in the Past Year
(By Weight Classification)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 18, 19, 98]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

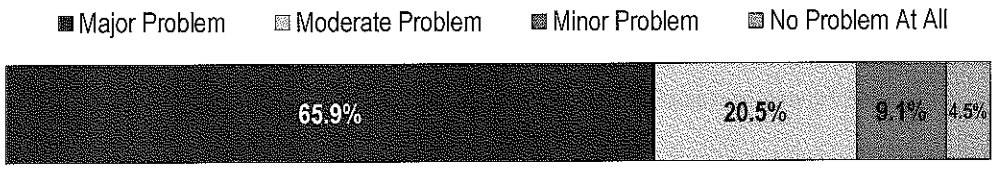
Notes:
- Asked of all respondents.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Prevalence of Obesity

> *Obesity is widespread in many communities, particularly troubling for children. Local markets often do not have fruits, vegetables and healthy meat options. Obesity is often intergenerational and therefore behavior and habits are difficult to change. – Community/Business Leader*
>
> *Our lifestyles. Take a trip to a mall and observe how many fall into the overweight/obese category. Go to a park and compare the number of people being active to the numbers you see in a mall. Look at what we've taken away from school children, recess, modified PE programs. After-school programs focus on academics, and many communities have "pay to play" sports programs. Marketing dollars spent by soda companies overwhelm any prevention education budgets. – Health Provider (Non-Physician)*
>
> *The rates of overweight and obesity in our community are high. – Social Services Representative*
>
> *Current studies of BMI in elementary school children places approximately 30% of children as obese. – Public Health Expert*
>
> *High obesity and diabetes rates. – Physician*

Access to Healthful Foods

> *The poor and low class citizens of the community do not have access to and cannot afford the market prices of fresh fruits and vegetables. – Health Provider (Non-Physician)*
>
> *Nutrition is sorely overlooked when attending to patient's chronic needs. Lack of resources available for obese children. Many patients are financially unable to provide balanced meals. – Health Provider (Non-Physician)*
>
> *Access to quality food and a basic knowledge about preparing nutritious food. – Health Provider (Non-Physician)*
>
> *Lack of access to high quality, affordable food due to lack of financial resources and lack of quality food retail. Lack of safe physical activity opportunities for community members. Low health/nutrition education. Lack of long-term exclusive breastfeeding. – Social Services Representative*

> *Poverty. Access to healthy affordable foods. Safe places. Low cost physical activity. Time and childcare. Stress. – Social Services Representative*

Education

> *Health education regarding proper nutrition and exercise is needed. – Community/Business Leader*
>
> *Lack of any consistent and connected education. There are programs here and there, but education and information for patients on this is very limited. – Physician*
>
> *Education on the issues, understanding why people don't put their health care first, usually because of family, work, children issues and time constraints. – Health Provider (Non-Physician)*
>
> *Early interventions and healthy behaviors should be integrated throughout all aspects of care. Our focus and interventions often exist when disease and complications already exist. Need intense counseling. For those insured, there is limited coverage for these interventions. – Health Provider (Non-Physician)*
>
> *Nutritional information and access to care and services, particularly for young people. – Community/Business Leader*
>
> *Practicing consistently on living a healthier life style. – Health Provider (Non-Physician)*
>
> *It all starts there. – Health Provider (Non-Physician)*

Access to Physical Activity

> *Food insecurity. Lack of access to free or low cost recreation. Lack of open spaces. Lack of education. Cultural barriers to diet modification and lack of access to primary care. – Public Health Expert*
>
> *Our communities are not built to support integration of physical activity into daily life like walking to school, grocery store. Too much reliance on prepared foods. Overweight and obesity are leading risk factors for many of our chronic diseases. – Health Provider (Non-Physician)*

Socioeconomic Challenges

> *Socio-economic challenges and stressed neighborhoods often make it difficult for residents to engage in healthful physical activity or purchase healthful/fresh foods. Information about healthy eating/healthy cooking is not consistently available. – Community/Business Leader*

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

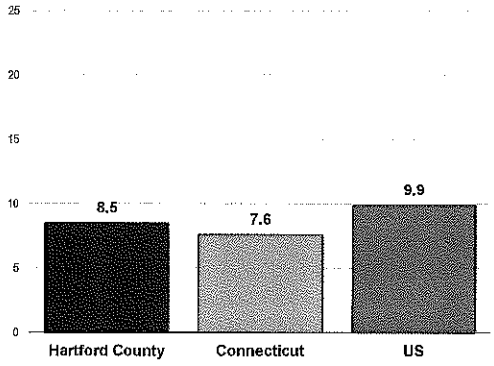
Related Age-Adjusted Mortality

Cirrhosis/Liver Disease. Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the area.

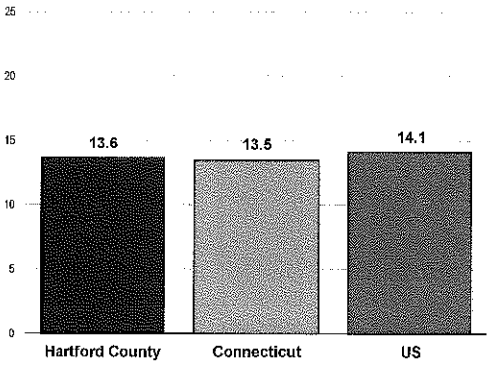
Drug-Induced Deaths. Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use (e.g., drug-induced Cushing's syndrome). A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. These deaths may also be either intentional (e.g., suicide) or unintentional (accidental). The following chart outlines local age-adjusted mortality for drug-induced deaths.

- Note the corresponding Healthy People 2020 targets.

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower



Drug-Induced Deaths: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives SA-11 and SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Alcohol Use

Current Drinkers. "Current drinkers" include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

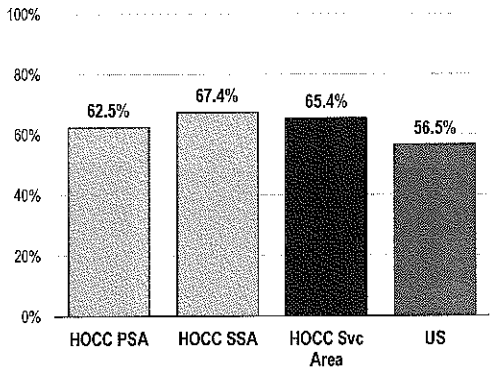
"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

Excessive Drinkers. Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

"On the day(s) when you drank, about how many drinks did you have on the average?"

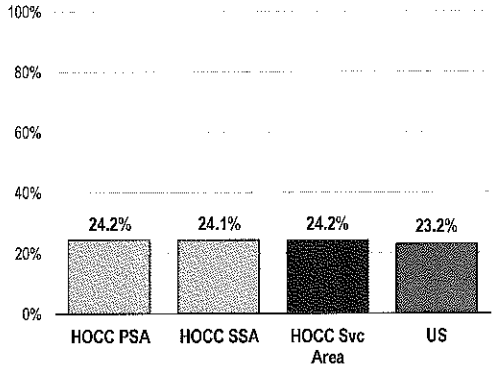
"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?"

Current Drinkers



Excessive Drinkers

Healthy People 2020 Target = 25.4% or Lower



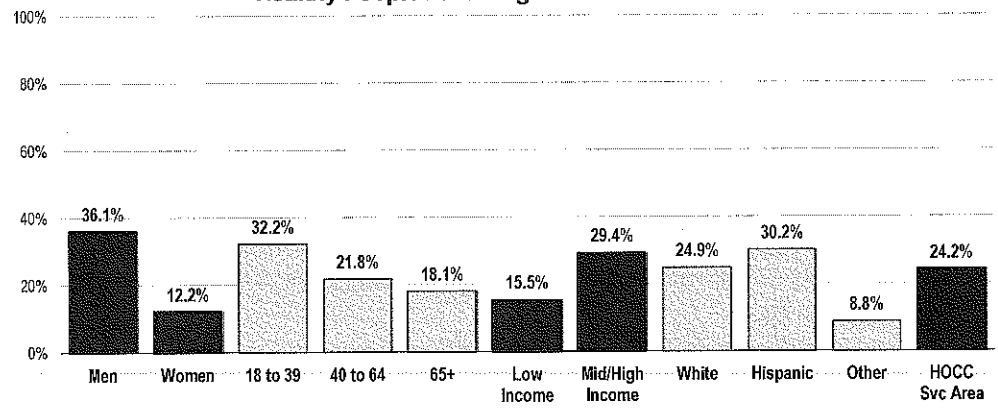
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 160, 164]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Current drinkers had at least one alcoholic drink in the past month.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers

(Total Area, 2015)

Healthy People 2020 Target = 25.4% or Lower

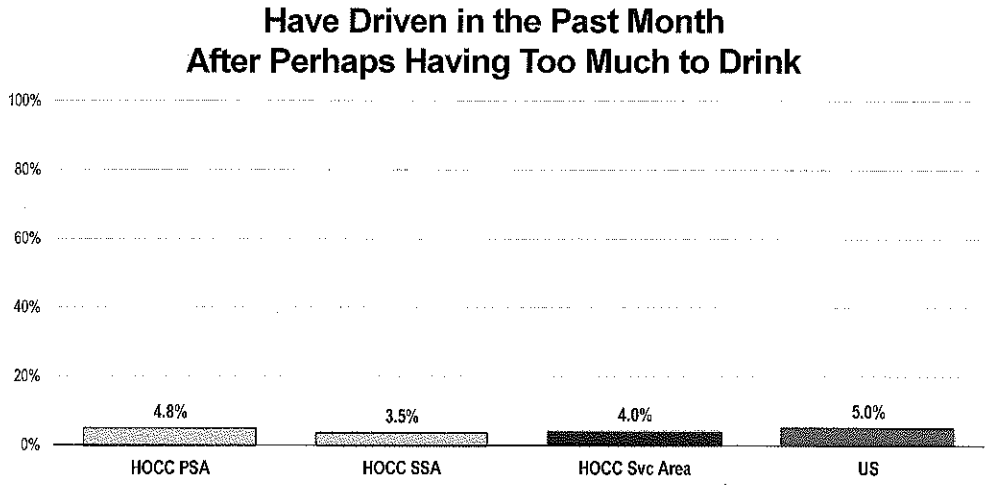


Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 164]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving. As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

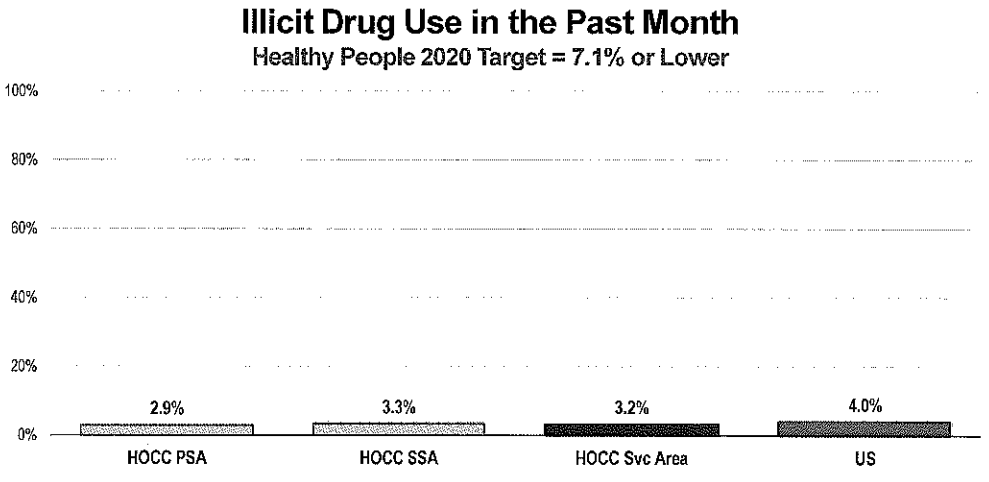
"During the past 30 days, how many times have you driven when you've had perhaps too much to drink?"



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 65]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Illicit Drug Use

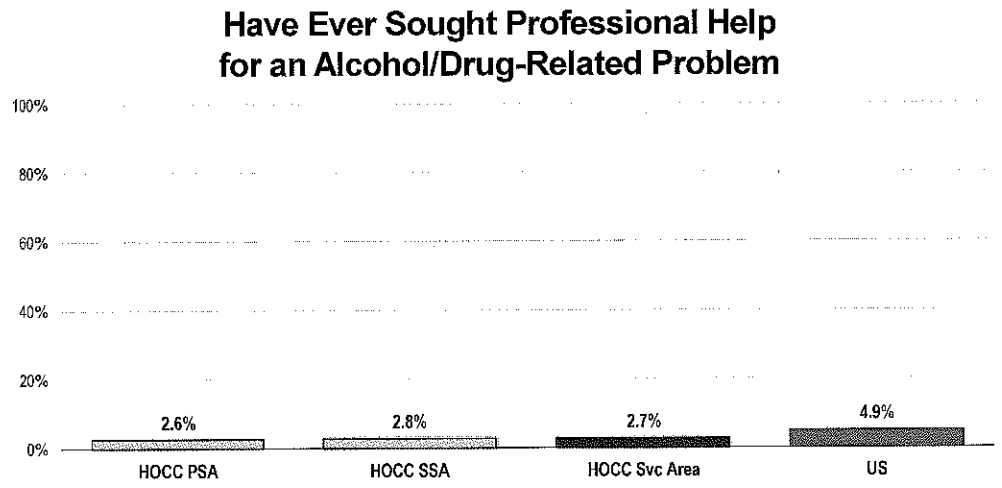
"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]
Notes: • Asked of all respondents.

Alcohol & Drug Treatment

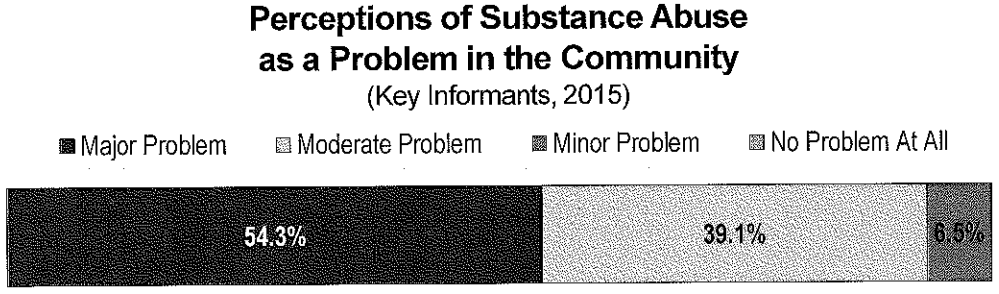
"Have you ever sought professional help for an alcohol or drug-related problem?"



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Resources

Inability to access mental health resources. Contact with the criminal justice system before having the opportunity to receive help for mental illness. Stigma. – Public Health Expert

Access to detox and in patient care. – Social Services Representative

Health insurance, not knowing where to go, not enough in-patient resources. – Community/Business Leader

There is a high prevalence of substance use in the Hartford community. Many struggle to find holistic treatment that address the underlying struggles often faced by those with addiction. – Community/Business Leader

There are limited resources available. – Health Provider (Non-Physician)

Lack of resources and follow up support. – Community/Business Leader

Not enough providers. – Physician

Not enough treatment beds. – Social Services Representative

Waiting lists, not ready for treatment, etc. – Social Services Representative

Perception of problem with alcohol. Lack of integrated medical and SA services. – Health Provider (Non-Physician)

Stigma

There is both a stigmatism and also a limited availability. Open slots for this care and treatment, especially inpatient and extended patient care. – Physician

Stigma, time, limited social supports, inconsistent messages from provider teams. – Health Provider (Non-Physician)

Denial, stigma. – Health Provider (Non-Physician)

Prevalence of Substance Abuse

High instance of substance abuse. – Health Provider (Non-Physician)

Silent epidemic in the young and old. – Public Health Expert

Increased inappropriate use of prescription drugs. Seems to be an increase in both self-reported and hospital admissions for drug misuse, abuse. More teenagers are experimenting with these relatively easy to acquire drugs and perceive they are safe because they were prescribed to someone as opposed to illegal drugs. – Health Provider (Non-Physician)

Access to Culturally-Appropriate Programs

Lack of culturally relevant and language-appropriate services, social determinants of health/stress. – Social Services Representative

Lack of specific programs for lesbian, gay, bisexual, transgender individuals. – Social Services Representative

Motivation & Support to Get Help

Lack of readiness to give up the habit, the lack of emotional and social support from family and or friends and for some people, the substance abuse environment is all they are accustomed to. – Health Provider (Non-Physician)

Most Problematic Substances

Key informants (who rated this as a "major problem") were further asked to identify what they view as the most problematic substances abused in the community.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	71.4%	0.0%	21.1%	19
Heroin or Other Opioids	14.3%	30.0%	42.1%	17
Cocaine or Crack	0.0%	30.0%	10.5%	8
Prescription Medications	0.0%	20.0%	10.5%	6
Marijuana	4.8%	5.0%	5.3%	3
Over-The-Counter Medications	4.8%	5.0%	5.3%	3
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	10.0%	0.0%	2
Inhalants	0.0%	0.0%	5.3%	1
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	4.8%	0.0%	0.0%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

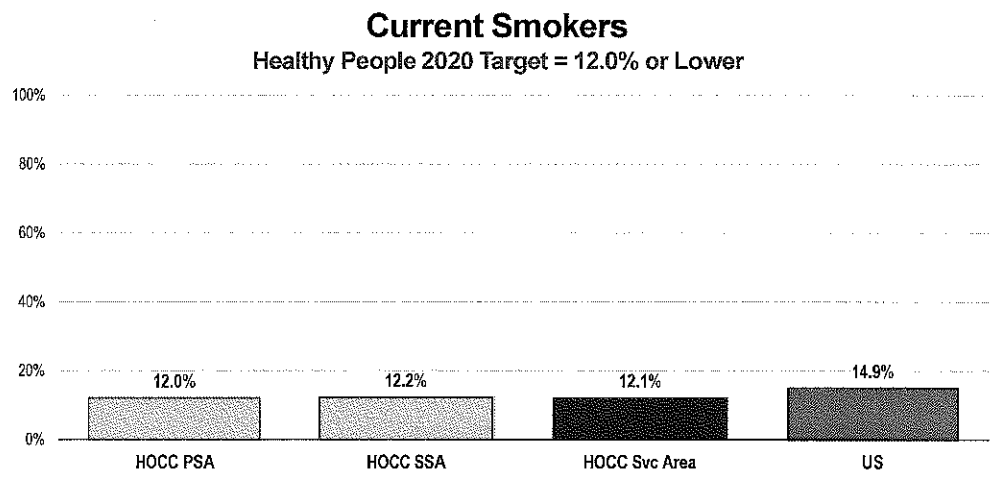
Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?"

- Note the Healthy People 2020 target.



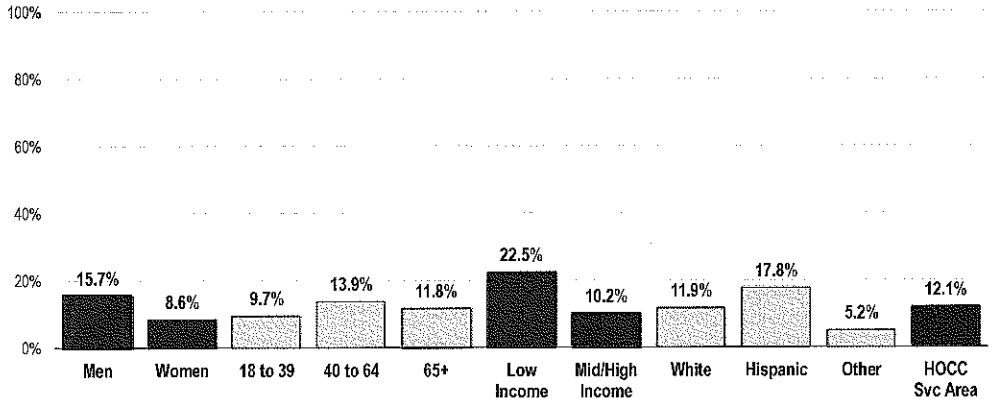
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes everyday or on some days).

Current Smokers

(HOCC Service Area, 2015)

Healthy People 2020 Target = 12.0% or Lower



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (everyday and some days).

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

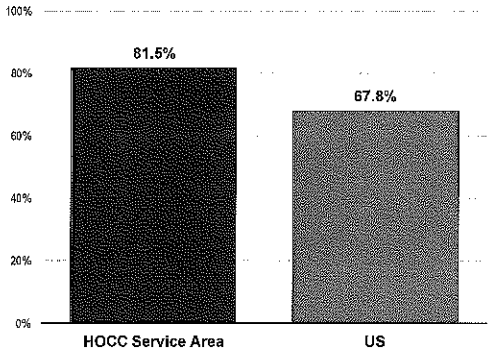
Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

- Healthy People 2020 (www.healthypeople.gov)

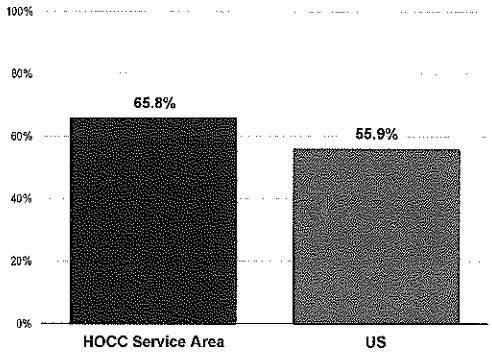
"In the past 12 months, has a doctor, nurse or other health professional advised you to quit smoking?" (Asked of respondents who smoke every day or on some days.)

"During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?" (Asked of respondents who smoke every day.)

Advised to Quit Smoking by a Healthcare Professional in Past Year
(Among Current Smokers)



Stopped Smoking for 1+ Days in Past Year in an Attempt to Quit
(Among Everyday Smokers)
Healthy People 2020 Target = 80% or Higher



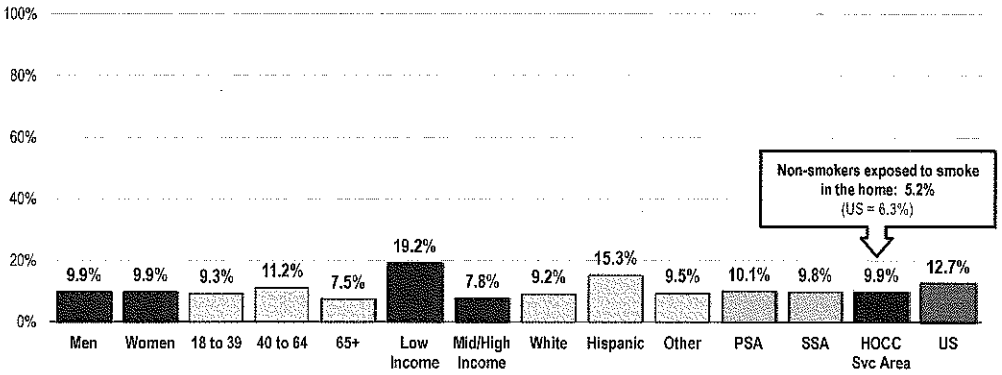
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 57, 58]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked among current and everyday smokers.

Secondhand Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only non-smokers and only households with children age 0-17.

Member of Household Smokes At Home
(HOCC Service Area, 2015)

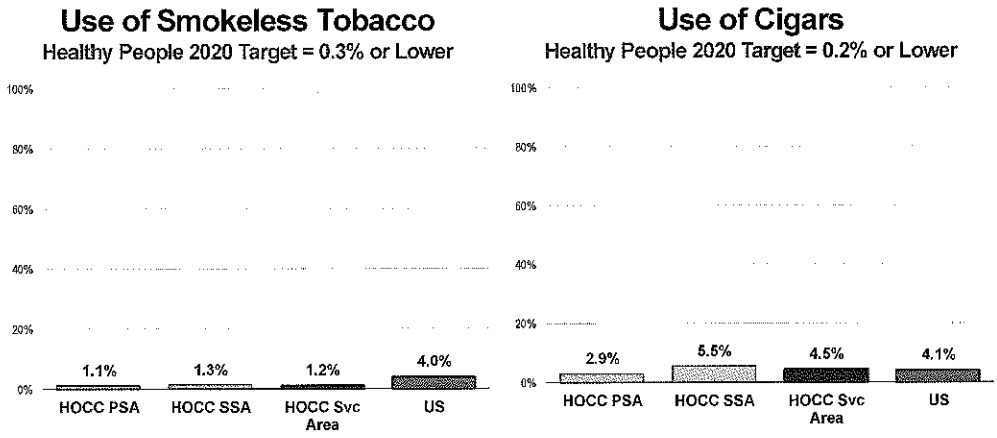


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59, 158]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Other Tobacco Use

"Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"

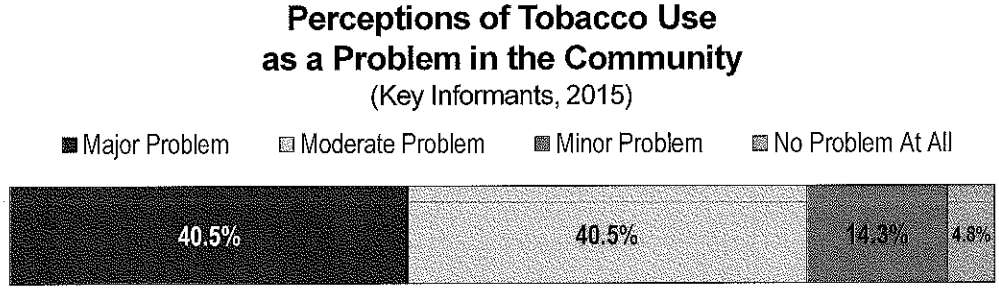
"Do you now smoke cigars every day, some days, or not at all?"



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 60, 61]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives TU-1.2 and TU-1.3]
Notes: • Asked of all respondents.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

At-Risk Populations

> *Tobacco use among Latinos and Blacks in CT is higher than among whites and higher than the state's average. Tobacco use is a major factor in development of chronic diseases. – Social Services Representative*
>
> *Tobacco use has been a part of the lesbian, gay, bisexual culture for decades. Step outside a gay bar to find many smokers. – Social Services Representative*
>
> *Cigarettes are the poor man's treatment for mental illness. Lack of education. Food insecurity, cigarettes help hunger pangs. – Public Health Expert*
>
> *Tobacco use is widespread in some communities particularly amongst individuals with current or prior substance abuse challenges. Tobacco has become very expensive, yet many with limited income still smoke. – Community/Business Leader*
>
> *Young smokers. – Health Provider (Non-Physician)*
>
> *Smoking continues to pose a significant health risk to our students. – Community/Business Leader*
>
> *High smoking in lower-income adults. – Physician*

Addiction

> *Addiction. – Health Provider (Non-Physician)*
>
> *Tobacco addiction and its impact on lung health. – Health Provider (Non-Physician)*

Prevalence of Smoking

> *Perceived high use rate. – Health Provider (Non-Physician)*

Lack of Smoking Cessation Programs

> *There are very few smoking cessation programs that are paid for by Husky or commercial insurers and group programs are almost never covered under insurance but often the most effective. – Physician*

Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

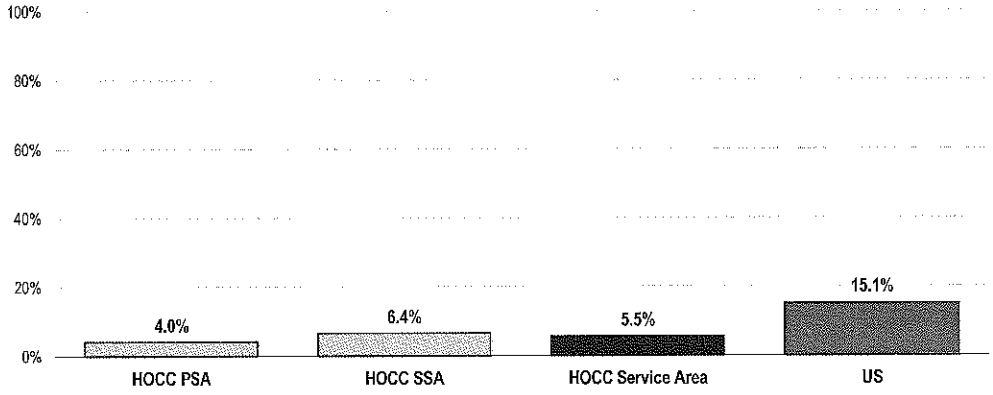
"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?"

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)



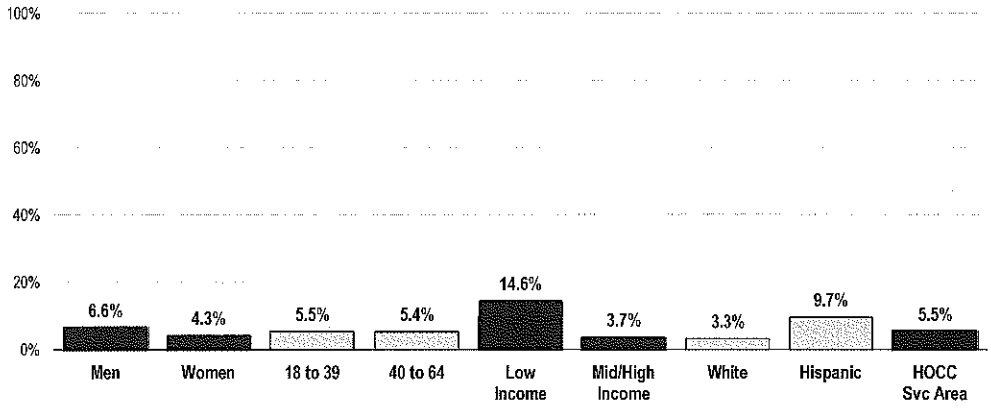
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64; HOCC Service Area, 2015)

Healthy People 2020 Target = 0.0% (Universal Coverage)



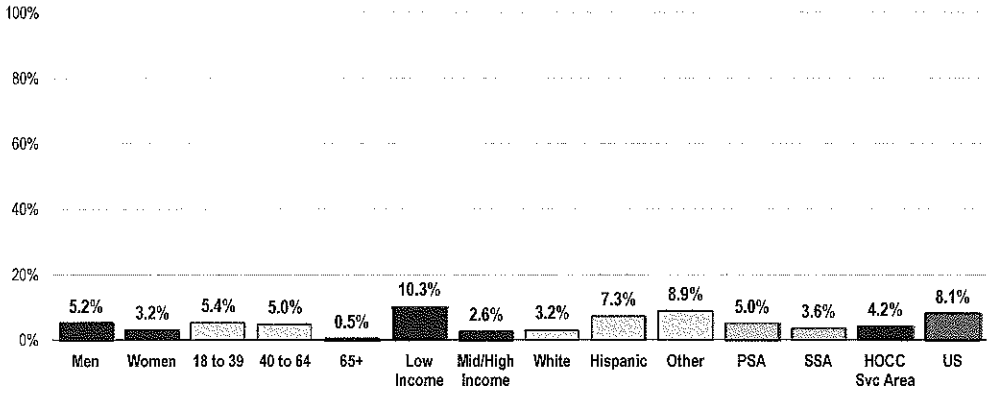
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among insured respondents only: ***"During the past 12 months, did you have health insurance coverage ALL of the time, or was there a time in the year when you did NOT have any health coverage?"***

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults; HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 79]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all insured respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

Barriers to Healthcare Access

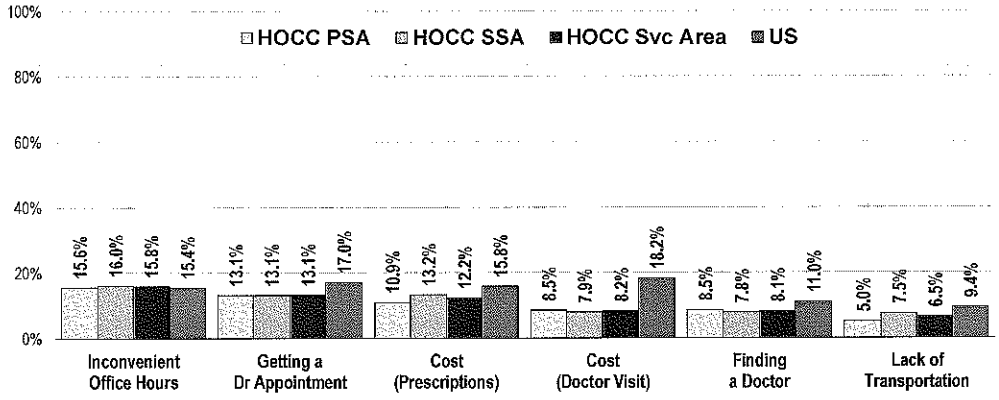
To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when...

- *... you needed medical care, but had **difficulty finding a doctor**?"*
- *... you had **difficulty getting an appointment** to see a doctor?"*
- *... you needed to see a **doctor, but could not because of the cost**?"*
- *... a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?"*
- *... you were not able to see a doctor because the **office hours were not convenient**?"*
- *... you needed a **prescription medicine, but did not get it because you could not afford it**?"*

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year



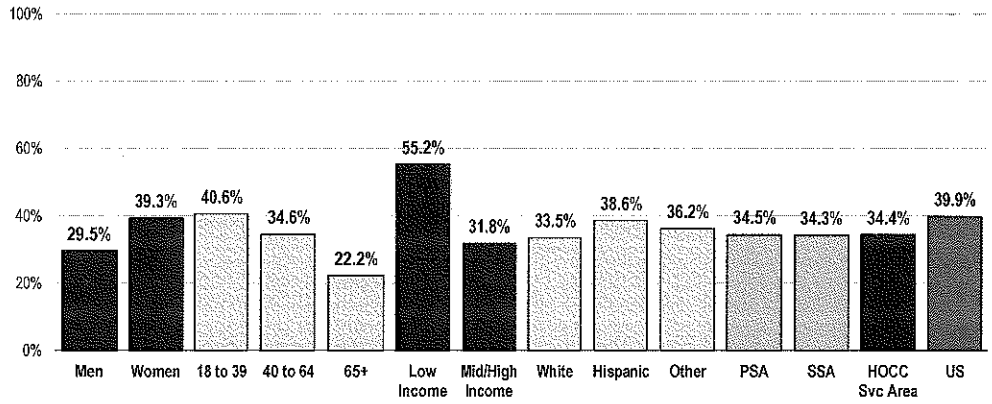
Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

The following chart reflects the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

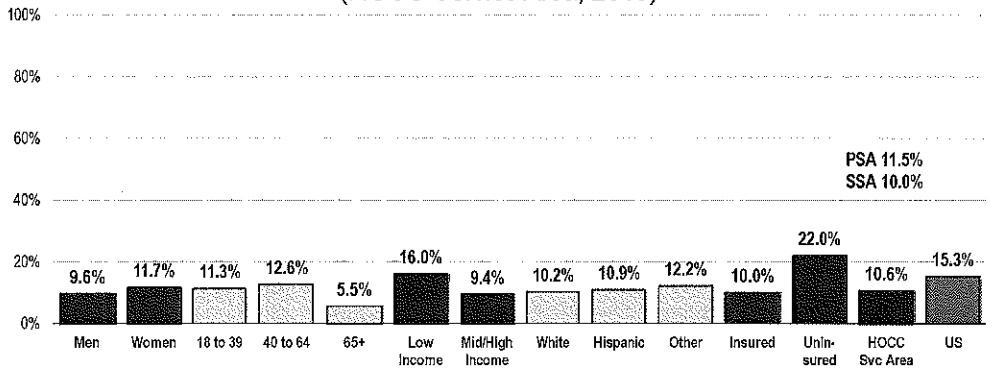
Notes:
- Asked of all respondents; represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prescriptions

"Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

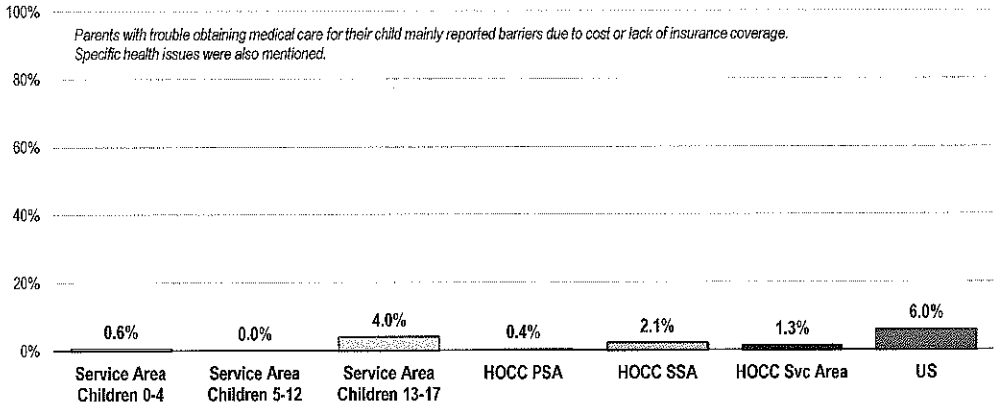
Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Parents of Children 0-17)



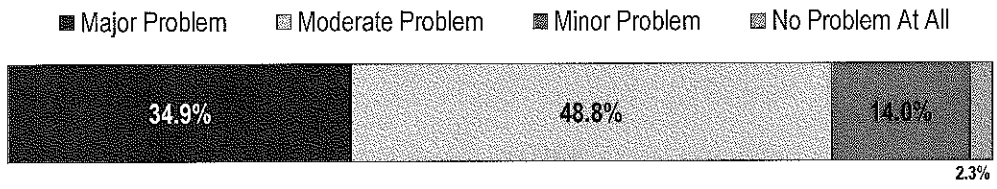
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 111-112]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants' perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Shortage of Physicians

> *Because of consolidation and because of the high expense associated with medical practice in Connecticut, there are simply some services that are limited due to the limited number of physicians in clinical practice. Further, while the focus has been on increasing health insurance coverage, the state of Connecticut has done very little to focus on the access issue or further supporting the care delivery infrastructure necessary as more and more consumers have coverage, causing coverage to be confused with access. – Physician*
>
> *Cost and the shortage of primary care physicians. – Health Provider (Non-Physician)*
>
> *Insurance and not enough doctors available. – Social Services Representative*
>
> *Inadequate access to subspecialty care. – Physician*
>
> *Accessing primary health care, behavioral health and patient navigation within the same facility. – Health Provider (Non-Physician)*

Insurance & Cost of Services

> *There are several challenges related to accessing health care service including affordability. Sometime the basic health care package doesn't cover all the services. Need education. Sometimes the community are not aware of services that are being provided. Accessibility. Service provided in the community are not at the standard care and to get that quality of service may take a person to travel beyond the community to get that care. – Social Services Representative*
>
> *The affordability of health insurance. – Social Services Representative*
>
> *There are a number of individuals that do not have health insurance. Also many residents don't attend regular preventive care appointments and many large community health centers are not accepting new patients for routine care. Transportation is a barrier as well as changing the way people think of about health. – Community/Business Leader*
>
> *Medication costs and access. – Health Provider (Non-Physician)*

Transportation

> *For some, the ability to have adequate transportation is one major factor. In addition, since I work with primarily mono lingual clients, it is difficult when there are no adequate personnel trained to serve as medical interpreters for these clients at medical office, FQHC's, etc. In the Hartford area, to my knowledge there is only one FQHC on the North end of Hartford, to some clients living in other areas, it is difficult to get there and moreover, whether they will have someone to provide understandable translation services. – Social Services Representative*
>
> *Transportation and compliance. – Social Services Representative*

Stigma

> *Stigma, lack of resources, lack of education. – Health Provider (Non-Physician)*
>
> *Stigma around and discrimination towards lesbian, gay, bisexual and transgender individuals and people living with HIV/AIDS. Lack of understanding and education on the part of health care providers. In some cases, barriers related to health insurance coverage, particularly for transgender individuals. – Social Services Representative*

Knowledge About Services

> *Lack of knowledge about services. Lack of coordination of care or rather, inability to access coordinated care. – Public Health Expert*

Ongoing Disease Management

> *Adherence to medications and clear medication regimes to minimize Polypharmacy. Inconsistencies with patient partnerships to establish clear goals of care with providers, patients and families. – Health Provider (Non-Physician)*

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") were further asked to identify they type of care they perceive as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	21.4%	**42.9%**	14.3%	**11**
Dental Care	14.3%	7.1%	**28.6%**	7
Specialty Care	7.1%	14.3%	**28.6%**	7
Primary Care	**35.7%**	7.1%	0.0%	6
Substance Abuse Treatment	7.1%	14.3%	14.3%	5
Chronic Disease Care	14.3%	0.0%	7.1%	3
All Services	0.0%	0.0%	7.1%	1
Elder Care	0.0%	7.1%	0.0%	1
Pain Management	0.0%	7.1%	0.0%	1

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

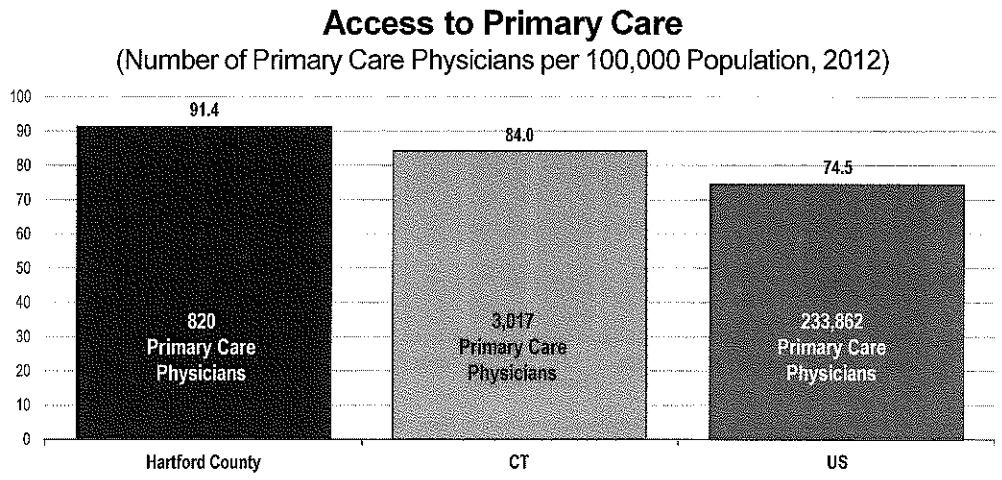
- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2012.
- Retrieved February 2015 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

"Is there a particular place that you usually go to if you are sick or need advice about your health?"

"What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor's office, a hospital emergency room, military or other VA healthcare, or some other place?"

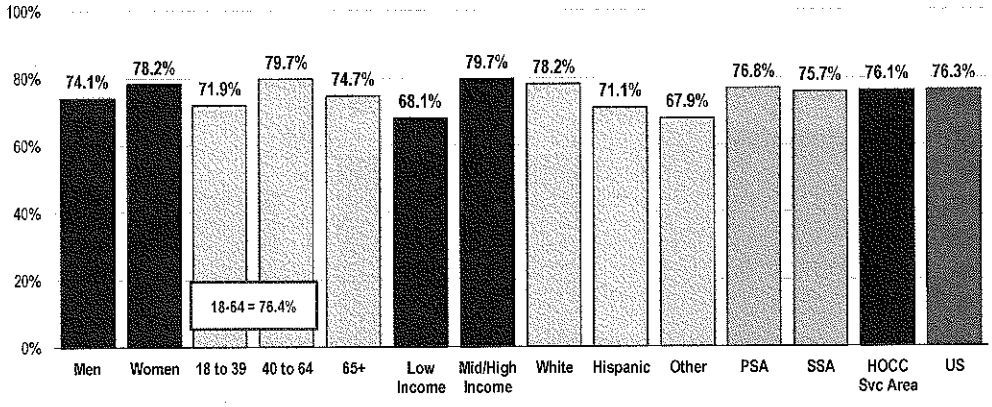
The following chart illustrates the proportion of the Hospital of Central Connecticut Service Area population with a specific source of ongoing medical care. Note that a hospital emergency room is not considered a specific source of ongoing care in this instance.

- Note the Healthy People 2020 objectives.

Have a Specific Source of Ongoing Medical Care

(HOCC Service Area, 2015)

Healthy People 2020 Target = 95.0% or Higher [All Ages]; ≥89.4% [18-64]; 100% [65+]



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 166-168]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov. [Objectives AHS-5.1, 5.3, 5.4]

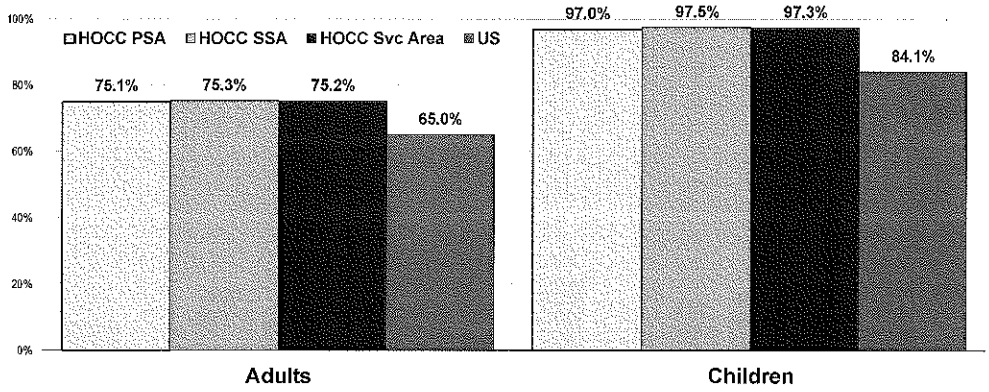
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Utilization of Primary Care Services

Adults: ***"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"***

Children: ***"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"***

Have Visited a Physician for a Routine Checkup in the Past Year

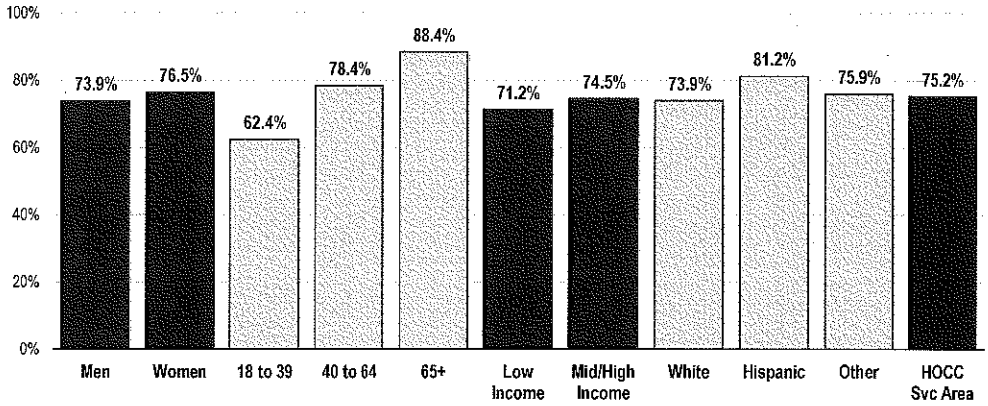


Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 113]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Adults: Have Visited a Physician for a Checkup in the Past Year

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

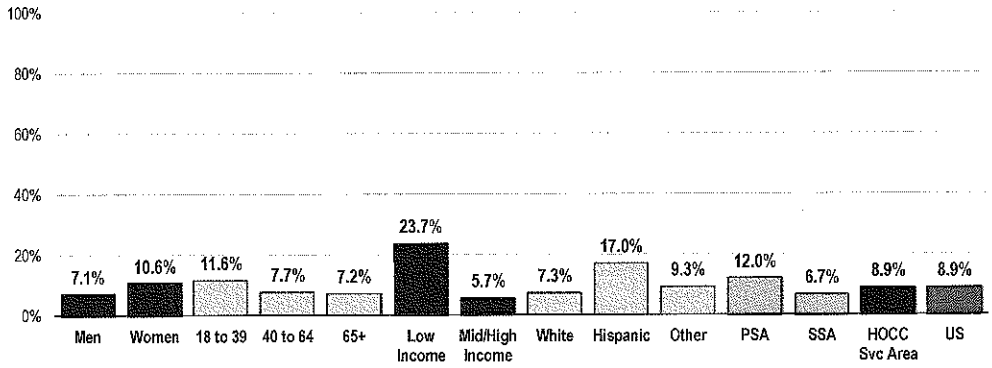
Emergency Room Utilization

"In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission." (Responses below reflect the percentage with two or more visits in the past year.)

"What is the main reason you used the emergency room instead of going to a doctor's office or clinic?"

Have Used a Hospital Emergency Room More Than Once in the Past Year

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices.**

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

Dental Care

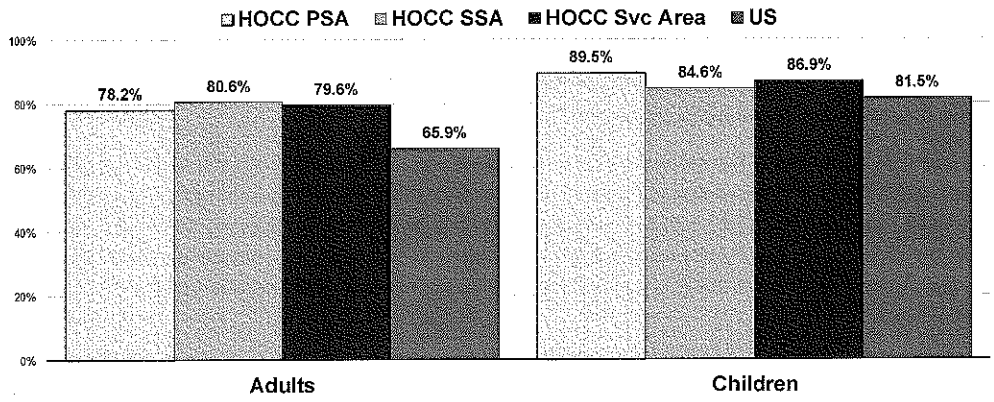
Adults: ***"About how long has it been since you last visited a dentist or a dental clinic for any reason?"***

Children Age 2-17: ***"About how long has it been since this child visited a dentist or dental clinic?"***

- Note the Healthy People 2020 target.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49% or Higher (Adults & Children)

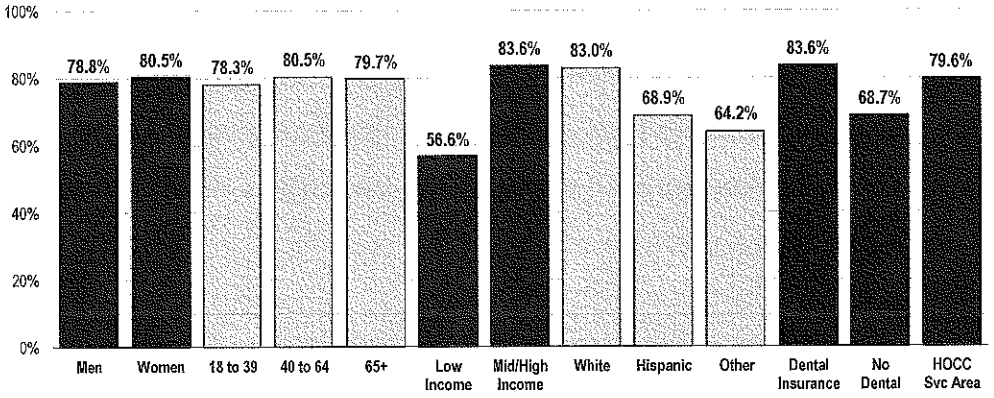


Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 21, 116]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Have Visited a Dentist or Dental Clinic Within the Past Year

(HOCC Service Area, 2015)

Healthy People 2020 Target = 49.0% or Higher



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents.
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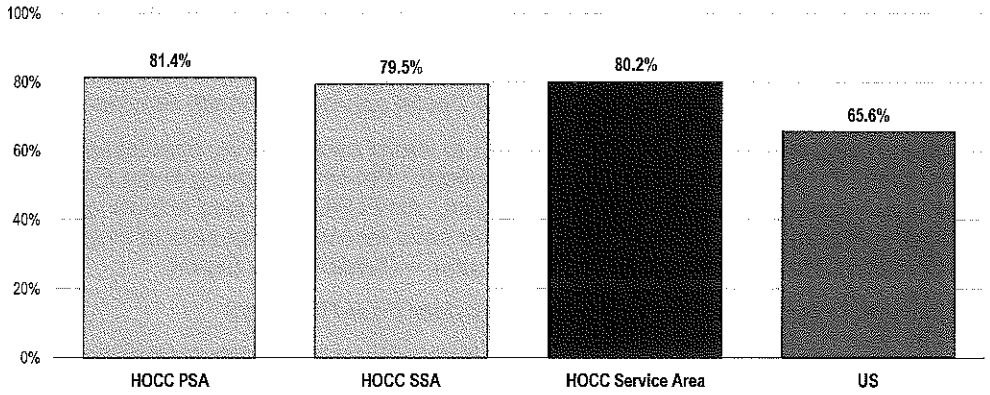
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Insurance

"Do you currently have any health insurance coverage that pays for at least part of your dental care?"

Have Insurance Coverage That Pays All or Part of Dental Care Costs



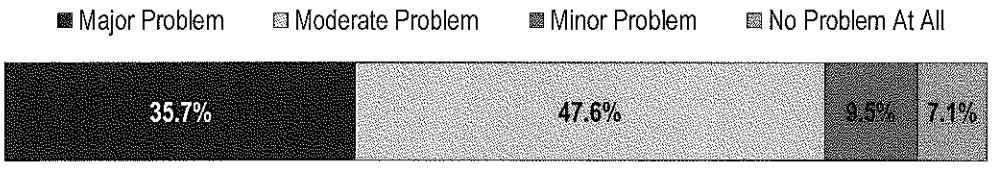
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Prevalence

> *High [dental] caries and unmet care needs. – Physician*
>
> *Evidence by the large number of people who access periodic free dental clinics. – Community/Business Leader*

Cost & Access to Care

> *Financial constraints and the cost of providing Dental services. – Health Provider (Non-Physician)*
>
> *Although Husky enrolled patients have access to dental care, booking appointments can be challenging, especially for emergency dental needs. Patients are going to the Emergency Room rather than receiving preventive Oral Health care. An FQHC is located in town, and they are expanding their dental operatory. However, we have received complaints of long wait times to get an appointment to receive emergency dental care. – Public Health Expert*
>
> *Not covered by some insurances. – Health Provider (Non-Physician)*
>
> *Consistent access to high quality dental care is not always achievable for low-income Hartford families. Dental issues are a significant cause of school absences. – Community/Business Leader*
>
> *While access to services has improved after the Medicaid rate increase, rural areas continue to lag behind. – Health Provider (Non-Physician)*
>
> *Not having access to dental will cause other medical problems. – Health Provider (Non-Physician)*
>
> *Limited education and access to education for many people. Access to care another contributing factor. – Health Provider (Non-Physician)*

Discrimination for People With HIV/AIDS

> *For people living with HIV/AIDS in particular, there is still discrimination and misunderstanding on the part of oral health professionals. – Social Services Representative*

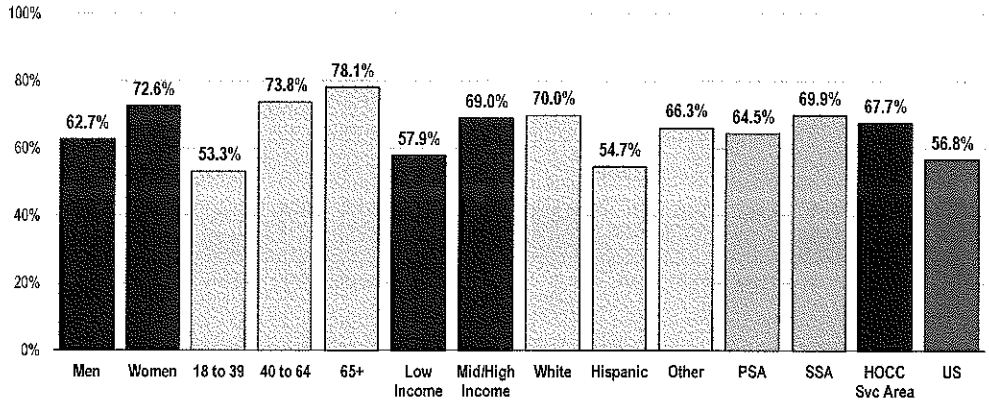
Vision Care

"When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light." (Responses in the following chart represent those with an eye exam within the past 2 years.)

See also *Vision & Hearing* in the Death, Disease & Chronic Conditions section of this report.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
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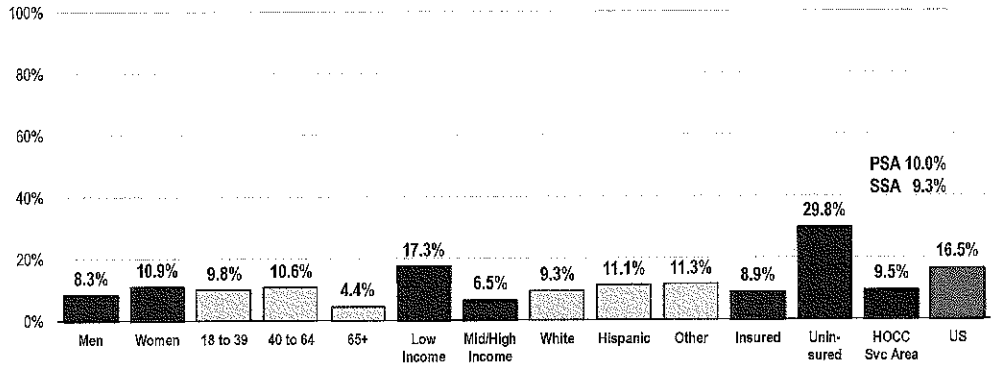
Local Resources

Perceptions of Local Healthcare Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair or poor?" (Combined "fair/poor" responses are outlined in the following chart.)

Perceive Local Healthcare Services as "Fair/Poor"

(HOCC Service Area, 2015)



Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- Access Health CT
- Access to Quality, Affordable Health Food
- AIDS CT
- Asylum Hill Family Services
- Brownstone Clinic
- Charter Oak
- Chronic Disease Management Programs
- Chrysalis Center
- Community Health Center
- Community Health Foundation
- Community Health Services
- Connecticut State Medical Society
- CT Transadvocacy Coalition
- Culturally Competent Nutritionists
- Curtis D. Robinson Center for Health Equity
- Diabetes Prevention Program
- FaithCare
- Federally Funded Clinics
- Federally Qualified Health Centers
- Hartford Gay and Lesbian Health Collective
- Hartford Health Care
- Health Department
- Hispanic Health
- Hospital Clinics
- Hospitals
- Intercommunity, Inc.
- Latino Community Services
- Malta
- Malta House of Care Mobile Clinic
- Planned Parenthood
- Private Providers
- Project STEP
- Revitalize
- Ryan White Medical Transportation Program
- Social Services
- Urban League of Greater Hartford
- Visiting Nurse Association
- Weight Loss Management Program

Arthritis, Osteoporosis & Chronic Back Conditions

- Charter Oak Health Center
- Community Health Services
- Connecticut Orthopaedic Society
- Connecticut State Medical Society
- Health Centers
- HHC Brown Stone Building
- Hospital Clinics

Cancer

- American Cancer Society
- Clinics
- Community Health Centers
- Community Health Services
- Community Health Workers/Health Educators
- Community/Senior Centers
- Curtis D. Robinson Center For Health Equity
- ECHN

- *The Hospital of Central Connecticut*
- *Helen and Harry Gray Cancer Center*
- *Hispanic Health Council*
- *Jefferson Radiology*
- *Local Health Department*
- *Local Support Groups*
- *Medicaid Breast and Cervical Cancer Program*
- *Planned Parenthood*
- *Primary Care Providers*
- *Public Health*
- *Quitline*
- *School Health Programs*
- *St. Francis Hospital*
- *Yale - Smilow Center*
- *YMCA Live Strong Program*

Chronic Kidney Disease

- *Connecticut State Medical Society*
- *Don't Know*
- *Hospital Clinics*
- *KEEP Health Screening*
- *Local Hospitals*
- *National Kidney Foundation*
- *Private Providers*
- *Sub-Specialists*

Dementias, Including Alzheimer's Disease

- *Adult Day Programs*
- *Alzheimer's Association*
- *Community Caregiver Support Groups*
- *Connecticut State Medical Society*
- *Elder Services*
- *Family Support Groups*
- *Private Assisted Living Facilities*
- *Rehab Facilities/Skilled Nursing Care*
- *Senior Center*
- *Visiting Nurses Association*

Diabetes

- *American Diabetes Association*
- *CHS*
- *COHC*
- *Community Health Centers*
- *Community Health Workers/Health Educators*
- *Community Support Groups*
- *Connecticut State Medical Society*
- *Curtis D. Robinson Center for Health Equity*
- *FaithCare*
- *Federally Funded Clinics*
- *Foot Clinics*
- *FQHC*
- *Freshplace*
- *The Hospital of Central Connecticut*
- *Health Department*
- *HHC*
- *HHC Brownstone*
- *Hospitals*
- *Local Church Programs*
- *Local Hospitals and Community Centers*
- *Malta House of Care Mobile Clinic*
- *Nutritional Educators*
- *Primary Care Providers*
- *Public Health*
- *Revitalize Hartford*
- *St. Francis Hospital*
- *YMCA*

Family Planning

- *Community Health Centers*
- *Community Health Workers/Health Educators*
- *Family Centers*
- *Healthy Start*
- *Hispanic Health Council Comadrona*

- *Program*
- *MIOP*
- *Nurturing Families*
- *Planned Parenthood*
- *School-Based Health Centers at HPHS, BHS and JMA*
- *Teen Pregnancy Prevention*
- *Women's Ambulatory Health Center*

Hearing & Vision

- *Audiology*
- *Connecticut State Medical Society*
- *CT Eye and ENT Society*
- *Ophthalmology Consults*

Heart Disease & Stroke

- *After School Programs*
- *American Heart Association*
- *Church Programs*
- *Community Health Centers*
- *Community Support Groups*
- *Emergency Room*
- *Employee Health and Wellness Programs*
- *FaithCare, Inc.*
- *Farmer's Market*
- *FQHC*
- *The Hospital of Central Connecticut*
- *The Hospital of Central Connecticut Heart Center*
- *Health Educators*
- *Local Hospitals and Community Centers*
- *Malta House of Care Mobile Clinic*
- *Primary Care Physicians*
- *Public Health*
- *St. Francis Care Women's Heart Program*
- *St. Francis Hospital*

HIV/AIDS

- *AIDS CT*
- *Charter Oak*
- *CHS*
- *Church*
- *Community Health Centers*
- *CTARC*
- *DPH*
- *Government Sponsored HIV Programs*
- *Hartford Gay and Lesbian Health Collective*
- *Health Educators*
- *Hispanic Health Council*
- *HIV CT*
- *HIV/AIDS Support Groups*
- *Infectious Disease Clinics*
- *Latino Community Services*
- *National Institute of Health*
- *Needle Exchange*
- *Planned Parenthood*
- *Ryan White*

Immunization & Infectious Diseases

- *Community Health Centers*
- *Department of Public Health*
- *Federally Funded Clinics*
- *Federally Qualified Health Centers*
- *Local Health Department*
- *Malta House of Care Mobile Clinic*

Infant & Child Health

- *Building Bridges*
- *Clinical Programs Specializing in Autism*
- *Comadrona and MIOP*
- *Community Health Center*
- *Connecticut Children's Medical Center*
- *CT DSS*
- *Easy Breathing Programs*

- *First Choice*
- *FQHC*
- *Healthy Start*
- *Help Me Grow*
- *Home Visiting*
- *Local Health Department*
- *Local Parks and Recreation Department*
- *Manchester Memorial Hospital*
- *School-Based Health Centers*
- *WIC*

Injury & Violence

- *2-1-1 Hotline*
- *Boys and Girls Club*
- *CCDAV*
- *Churches and Youth Groups*
- *Community Mental Health Providers*
- *Conflict Resolution Programs*
- *Connecticut Behavioral Health Partnership*
- *Domestic Violence Shelters*
- *DPH Injury Prevention*
- *Hartford Health Care*
- *Health Educators*
- *Injury Prevention Center*
- *Intercommunity, Inc.*
- *Local Health Department*
- *Neighborhood Violence Prevention Programs*
- *OPP*
- *Prevention Programs for Car Seats*
- *Public Health*
- *Safe Kids Connecticut*
- *School Social Workers*
- *School-Based Health Centers*
- *Strengthening Families Framework*
- *Suicide Prevention Advisory Board*
- *Teen Driver Laws*
- *Village for Families and Children*
- *Wheeler Clinic*
- *YMCA*

Mental Health

- *2-1-1 Crisis Intervention*
- *ADRC*
- *Behavioral Health Partnership*
- *Capital Region Mental Health*
- *Catholic Charities*
- *Child Guidance Clinic*
- *Chrysalis*
- *City of Hartford Comm on Addiction and Public Health*
- *Community Health Resources*
- *Community Mental Health Providers*
- *Connecticut Behavioral Health Partnership*
- *Connecticut Psychiatric Society*
- *Connecticut State Medical Society*
- *DMHAS*
- *ECHN*
- *Employee Assistance Programs*
- *EMPS*
- *FQHC*
- *Genesis*
- *Hartford Behavioral Health*
- *Hartford HealthCare*
- *Independent Non-Profits*
- *Institute for Living*
- *Intercommunity, Inc.*
- *IOL*
- *LCS/Hartford Behavioral Health*
- *Local Health Department*
- *MACC Charities*
- *Manchester Senior, Adult and Family Services*
- *Manchester Youth Services Bureau*

- *MCSC*
- *Private Providers*
- *Rushford Center*
- *School-Based Health Centers*
- *Social Workers*
- *The Village*
- *Village for Families and Children*
- *Wheeler Clinic*

Nutrition, Physical Activity & Weight

- *Bariatric Program and Comprehensive Evaluations*
- *Black Nurses Association*
- *CHCs and Clinics*
- *CHS*
- *Church and Town Pantries*
- *COHC*
- *Cooking Matters*
- *Early Childhood Programs*
- *Employers Supporting Breastfeeding*
- *FaithCare, Inc.*
- *Farmer's Market*
- *Fast Food Restaurants*
- *Food Pantry*
- *Food Share*
- *FQHC*
- *Fresh Fruits and Vegetables Distribution Vans*
- *Hartford Behavioral Health*
- *Hartford Childhood Wellness Alliance*
- *Hartford Food System*
- *Hartford HealthCare*
- *HHC Brownstone*
- *HHC's Breastfeeding*
- *Hispanic Nurses Association*
- *Intercommunity, Inc.*
- *Manchester Health Department*
- *Manchester Recreation Department*
- *Manchester Youth Services Bureau*
- *Mayor's Taskforce on Childhood Obesity*
- *Parks and Recreation Department*
- *Planning and Zoning Departments*
- *Public Health*
- *School-Based Health Centers*
- *Schools*
- *SNAP*
- *Summer Food*
- *Weight Management and Lifestyle Programs*
- *Wellness Committee at Sanchez School*
- *WIC*
- *YMCA*
- *Yoga*
- *YWCA*

Oral Health

- *Charter Oak Health Center*
- *Community Health Center*
- *Community Health Services*
- *CT Children's Medical Center*
- *First Choice*
- *FQHC*
- *Free Dental Cleaning Fairs*
- *Hartford Gay and Lesbian Health Collective*
- *HHC Brownstone*
- *Mission of Mercy*
- *Mobile Dental Clinics*
- *Private Dentists*
- *Saint Francis Health Care*

Respiratory Diseases

- *American Lung Association*
- *Building Bridges*
- *CHS*
- *Classes at Local Hospitals*

- *COHC*
- *Community Health Centers*
- *Easy Breathing Program*
- *HHC*
- *HUD*
- *Keep the City Clean Projects*
- *Local Health Department*
- *Malta House of Care Mobile Clinic*
- *Public Health*
- *School-Based Health Centers*
- *State Department of Public Health Smoking Cessation*
- *Support Groups*
- *Visiting Nurses Association*

Sexually Transmitted Diseases

- *Charter Oak and CHS*
- *CHS*
- *City of Hartford Health and Human Services STD Clinic*
- *COHC*
- *FQHC*
- *Hartford Gay and Lesbian Health Collective*
- *Hartford Health Department*
- *The Hospital of Central Connecticut Brownstone Clinic*
- *HHC*
- *Latino Community Services/STI Testing Clinic*
- *Local Health Department*
- *Planned Parenthood*
- *Ryan White*
- *School-Based Health Centers*
- *Schools*
- *St. Francis, CHS, Charter Oak and CCMC*
- *The Health Collective*
- *Various Clinic and Hospital Services*
- *Walk-in Clinics*

Substance Abuse

- *Alcohol and Drug Rehabilitation*
- *Alcoholics Anonymous*
- *Catholic Charities*
- *Community Health Services*
- *Community Renewal Team*
- *Community-Based MH/SA Providers*
- *Department of Mental Health and Addiction Services*
- *FQHC*
- *Halfway Houses*
- *Hartford Behavioral Health*
- *Hartford Fishfry*
- *Hartford HealthCare*
- *Institute for Hispanic Families*
- *Institute of Living*
- *Intercommunity, Inc.*
- *IOL*
- *LCS/Project STEP*
- *Linkage to Care*
- *Medicaid*
- *Narcotics Anonymous*
- *Rushford Center*
- *Social Workers*
- *Village for Families and Children*
- *Wheeler Clinic*
- *Youth Challenge*

Tobacco Use

- *Community Health Center*
- *Community Health Providers*
- *FQHC*
- *Hospital-Based Program*
- *Intercommunity, Inc.*
- *Local Health Department*
- *Local Pharmacy*

Medicaid

Public Health

Quit Line

SA/MH Providers

School-Based Health Center

Smoking Cessation Program Incorporated Into Care

State Smoking Cessation Program

Village for Families and Children

Huber, Jack

From: Foster, Tillman
Sent: Thursday, December 03, 2015 4:25 PM
To: Barbara Durdy (HHC)
Cc: Carolyn Freiheit (Hosp of Central CT & MidState); Hansted, Kevin; Huber, Jack; Roberts, Karen
Subject: 15-32023-CON
Attachments: Late Files HOCC Hearing.doc; Financial Workbook termination - Historical Service Specific.xlsx

Good afternoon Ms. Durdy – Please find attached a listing of OHCA's late file requests from the December 2, 2015 public hearing.
Also attached is a an **MS Excel** spreadsheet in order to report the historical financial information specific to the Inpatient and
Outpatient Pediatric services proposed for termination. Please feel free to contact me or Jack Huber if you have any questions
regarding the attached documents.

Please provide your responses to OHCA's late file requests no later than **Monday, December 21, 2015**.

Thank you. Regards, Tillman

Tillman Foster
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA, P.O. Box 340308
Hartford, CT 06134
Phone: (860) 418-7031
Fax: (860) 418-7053
Email: Tillman.Foster@CT.GOV

Prior 3 Year Analysis

			(1)	(2)	(3)		(4)	(5)	(6)	
LINE	Total Entity:		FY13	FY13	FY13		FY14	FY14	FY14	
			Actual	IP Pediatric	Actual w /o		Actual	IP Pediatric	Actual w /o	
	Description		Results	Service	IP Ped Service		Results	Service	IP Ped Service	
A.	OPERATING REVENUE									
1	Total Gross Patient Revenue				$0				$0	
2	Less: Allowances				$0				$0	
3	Less: Charity Care				$0				$0	
4	Less: Other Deductions				$0				$0	
	Net Patient Service Revenue		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
5	Medicare				$0				$0	
6	Medicaid				$0				$0	
7	CHAMPUS & TriCare				$0				$0	
8	Other				$0				$0	
	Total Government		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
9	Commercial Insurers				$0				$0	
10	Uninsured				$0				$0	
11	Self Pay				$0				$0	
12	Workers Compensation				$0				$0	
13	Other				$0				$0	
	Total Non-Government		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	Net Patient Service Revenue[a] (Government+Non-Government)		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
14	Less: Provision for Bad Debts				**$0**				**$0**	
	Net Patient Service Revenue less provision for bad debts		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
15	Other Operating Revenue				**$0**				**$0**	
17	Net Assets Released from Restrictions				**$0**				**$0**	

Prior 3 Year Analysis

			(1)	(2)	(3)		(4)	(5)	(6)	
LINE	Total Entity:		FY13	FY13	FY13		FY14	FY14	FY14	
			Actual	IP Pediatric	Actual w /o		Actual	IP Pediatric	Actual w /o	
	Description		Results	Service	IP Ped Service		Results	Service	IP Ped Service	
	TOTAL OPERATING REVENUE		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
B.	**OPERATING EXPENSES**									
1	Salaries and Wages				$0				$0	
2	Fringe Benefits				$0				$0	
3	Physicians Fees				$0				$0	
4	Supplies and Drugs				$0				$0	
5	Depreciation and Amortization				$0				$0	
6	Provision for Bad Debts-Other[b]				$0				$0	
7	Interest Expense				$0				$0	
8	Malpractice Insurance Cost				$0				$0	
9	Lease Expense				$0				$0	
10	Other Operating Expenses				$0				$0	
	TOTAL OPERATING EXPENSES		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	INCOME/(LOSS) FROM OPERATIONS		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	NON-OPERATING REVENUE				**$0**				**$0**	
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	Principal Payments									
C.	**PROFITABILITY SUMMARY**									

Prior 3 Year Analysis

			(1)	(2)	(3)		(4)	(5)	(6)	
LINE	Total Entity:		FY13	FY13	FY13		FY14	FY14	FY14	
			Actual	IP Pediatric	Actual w /o		Actual	IP Pediatric	Actual w /o	
	Description		Results	Service	IP Ped Service		Results	Service	IP Ped Service	
1	Hospital Operating Margin		0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	
2	Hospital Non Operating Margin		0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	
3	Hospital Total Margin		0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	
D.	FTEs				0				0	
E.	VOLUME STATISTICS[c]									
1	Inpatient Discharges				0				0	
	TOTAL VOLUME		0	0	0		0	0	0	

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB,

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing ser

Prior 3 Year Analysis

		(7)	(8)	(9)	
LINE	Total Entity:	FY15	FY15	FY15	
		Actual	IP Pediatric	Actual w /o	
	Description	Results	Service	IP Ped Service	
A.	**OPERATING REVENUE**				
1	Total Gross Patient Revenue			$0	
2	Less: Allowances			$0	
3	Less: Charity Care			$0	
4	Less: Other Deductions			$0	
	Net Patient Service Revenue	**$0**	**$0**	**$0**	
5	Medicare			$0	
6	Medicaid			$0	
7	CHAMPUS & TriCare			$0	
8	Other			$0	
	Total Government	**$0**	**$0**	**$0**	
9	Commercial Insurers			$0	
10	Uninsured			$0	
11	Self Pay			$0	
12	Workers Compensation			$0	
13	Other			$0	
	Total Non-Government	**$0**	**$0**	**$0**	
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	
14	Less: Provision for Bad Debts			**$0**	
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	
15	Other Operating Revenue			**$0**	
17	Net Assets Released from Restrictions			**$0**	

Prior 3 Year Analysis

		(7)	(8)	(9)	
LINE	**Total Entity:**	**FY15**	**FY15**	**FY15**	
		Actual	**IP Pediatric**	**Actual w /o**	
	Description	**Results**	**Service**	**IP Ped Service**	
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	
B.	**OPERATING EXPENSES**				
1	Salaries and Wages			$0	
2	Fringe Benefits			$0	
3	Physicians Fees			$0	
4	Supplies and Drugs			$0	
5	Depreciation and Amortization			$0	
6	Provision for Bad Debts-Other[b]			$0	
7	Interest Expense			$0	
8	Malpractice Insurance Cost			$0	
9	Lease Expense			$0	
10	Other Operating Expenses			$0	
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	
	NON-OPERATING REVENUE			**$0**	
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**	
	Principal Payments				
C.	**PROFITABILITY SUMMARY**				

Prior 3 Year Analysis

		(7)	(8)	(9)	
LINE	**Total Entity:**	**FY15**	**FY15**	**FY15**	
		Actual	**IP Pediatric**	**Actual w /o**	
	Description	**Results**	**Service**	**IP Ped Service**	
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**	
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**	
D.	**FTEs**			**0**	
E.	**VOLUME STATISTICS[c]**				
1	Inpatient Discharges			**0**	
	TOTAL VOLUME	**0**	**0**	**0**	

[a]Total amount should equal the total amount on c

[b]Provide the amount of any transaction associate No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient stavices which will change due to the proposal.

Prior 3 Year Analysis

			(1)	(2)	(3)		(4)	(5)	(6)	
LINE	Total Entity:		FY13	FY13	FY13		FY14	FY14	FY14	
			Actual	OP Pediatric	Actual w /o		Actual	OP Pediatric	Actual w /o	
	Description		Results	Service	OP Ped Service		Results	Service	OP Ped Service	
A.	**OPERATING REVENUE**									
1	Total Gross Patient Revenue				$0				$0	
2	Less: Allowances				$0				$0	
3	Less: Charity Care				$0				$0	
4	Less: Other Deductions				$0				$0	
	Net Patient Service Revenue		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
5	Medicare				$0				$0	
6	Medicaid				$0				$0	
7	CHAMPUS & TriCare				$0				$0	
8	Other				$0				$0	
	Total Government		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
9	Commercial Insurers				$0				$0	
10	Uninsured				$0				$0	
11	Self Pay				$0				$0	
12	Workers Compensation				$0				$0	
13	Other				$0				$0	
	Total Non-Government		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	Net Patient Service Revenue[a] (Government+Non-Government)		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
14	Less: Provision for Bad Debts				**$0**				**$0**	
	Net Patient Service Revenue less provision for bad debts		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
15	Other Operating Revenue				**$0**				**$0**	
17	Net Assets Released from Restrictions				**$0**				**$0**	
	TOTAL OPERATING REVENUE		**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	

B.	**OPERATING EXPENSES**								
1	Salaries and Wages			$0				$0	
2	Fringe Benefits			$0				$0	
3	Physicians Fees			$0				$0	
4	Supplies and Drugs			$0				$0	
5	Depreciation and Amortization			$0				$0	
6	Provision for Bad Debts-Other[b]			$0				$0	
7	Interest Expense			$0				$0	
8	Malpractice Insurance Cost			$0				$0	
9	Lease Expense			$0				$0	
10	Other Operating Expenses			$0				$0	
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	NON-OPERATING REVENUE			**$0**				**$0**	
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
	Principal Payments								
C.	**PROFITABILITY SUMMARY**								
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**	
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**	
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**	
D.	**FTEs**			**0**				**0**	
E.	**VOLUME STATISTICS[c]**								
1	Outpatient Visits			**0**				**0**	
	TOTAL VOLUME	**0**	**0**	**0**		**0**	**0**	**0**	

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASI
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing s

(7)	(8)	(9)	
FY15	**FY15**	**FY15**	
Actual	**OP Pediatric**	**Actual w /o**	
Results	**Service**	**OP Ped Service**	
		$0	
		$0	
		$0	
		$0	
$0	**$0**	**$0**	
		$0	
		$0	
		$0	
		$0	
$0	**$0**	**$0**	
		$0	
		$0	
		$0	
		$0	
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$0	**$0**	**$0**	
$0	**$0**	**$0**	
		$0	
$0	**$0**	**$0**	
		$0	
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$0	**$0**	**$0**	

		$0	
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		$0	
		$0	
$0	**$0**	**$0**	
$0	**$0**	**$0**	
		$0	
$0	**$0**	**$0**	
0.0%	**0.0%**	**0.0%**	
0.0%	**0.0%**	**0.0%**	
0.0%	**0.0%**	**0.0%**	
		0	
		0	
0	**0**	**0**	

B, No.2011-07, July 2011.

ervices which will change due to the proposal.

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Hospital of Central Connecticut

DN: 15-32023-CON

Hearing Date: December 2, 2015

Time: 5:00 p.m.

Proposal: The Hospital of Central Connecticut's Proposal to Terminate its Inpatient and Outpatient Pediatric Services

OHCA Exhibit #	Description
1	Listing of Asthma Programs itemized by the following categories: Provided by, funded by and/or supported by the Hospital of Central Connecticut.
2	A. Historical Financials for the Hospital's **Inpatient Pediatric Service** for FYs 2013 through 2015. B. Historical Financials for the Hospital's **Outpatient Pediatric Clinic Service** for FYs 2013 through 2015.
3	Revised Financial Projections taking into consideration the changing revenue/expense considerations discussed during the public hearing. An explanation of the changes made in developing the revised financial projections should accompany the projections.
4	

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

HOSPITAL OF CENTRAL CONNECTICUT

APPLICATION FOR THE TERMINATION OF INPATIENT AND OUTPATIENT PEDIATRIC SERVICES

DOCKET NO. 15-32023-CON

DECEMBER 2, 2015

5:05 P.M.

NEW BRITAIN HIGH SCHOOL
110 MILL STREET
NEW BRITAIN, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Hospital of Central Connecticut, Application for the Termination of its Inpatient and Outpatient Pediatric Services, held at New Britain High School, 110 Mill Street, New Britain, Connecticut, on December 2, 2015 at 5:05 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good evening, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 15-32023-CON, is being held on December 2, 2015 to consider the Hospital of Central Connecticut's application for the termination of its inpatient and outpatient pediatric services.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I have been

designated by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this matter.

The staff members assigned to assist me in this matter are Karen Roberts and Jack Huber, and the hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

The Hospital of Central Connecticut has been designated as a party in this proceeding.

At this time, I will ask staff to read into the record those documents appearing in OHCA's Table of the Record in this matter.

All documents have been identified in the Table of the Record for reference purposes. Mr. Huber?

MR. JACK HUBER: Thank you. For the record, my name is Jack Huber. Prior to today's hearing, a copy of the Table of the Record was conveyed to the Applicant. The Table of the Record identifies Exhibits A through H.

If you and the Applicant have no objections, in the interest of time, I would like to

suggest we forego the formal reading of each individual exhibit into the record and offer said Table of the Record in its entirety for inclusion in today's proceeding. The court reporter has received a copy of the Table.

HEARING OFFICER HANSTED: Thank you. We have one additional exhibit we want to have entered, which was presented by the Applicant before the Hearing. It's the letter of support, and it's a letter of support by Mr. Bruce Baxter, dated November 23, 2015, and that we will mark it as Exhibit I.

Are there any other exhibits that needed to be entered into the record?

MR. HUBER: Not at this time.

HEARING OFFICER HANSTED: Counsel, do you have one?

MS. JOAN FELDMAN: We have one. It's from the Mayor of the City of New Britain.

HEARING OFFICER HANSTED: Okay, thank you. And that will be marked as Exhibit J. Thank you, counsel. Counsel, are there any objections to any of the exhibits?

MS. FELDMAN: We have no objections.

HEARING OFFICER HANSTED: Thank you. This

evening, what we will do is first hear from the Applicant for an overview of the project, and then OHCA will ask some questions of the Applicant. After that, we will take a short break, and, if there are any members of the public here, who would like to give a comment on the project, we will hear from those individuals.

At this time, all the individuals, who are going to testify on behalf of the Applicant, please stand, raise your right hand and be sworn in by the court reporter.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Thank you, everyone. And just as a reminder, before you testify, please just identify yourself for the record, and for those individuals, who have submitted pre-filed testimony, please adopt that for me on the record. I'd appreciate that.

All set? Okay and the Applicant may proceed at this time.

DR. ANNMARIE GOLIOTO: Thank you. My name is Dr. Annmarie Golioto, the Chief of Pediatrics and a Neonatologist representing the Hospital of Central Connecticut.

I did file testimony and would like to adopt that pre-filed testimony as my own.

HEARING OFFICER HANSTED: Thank you.

DR. GOLIOTO: So I appreciate the opportunity to speak on behalf of this proposal. As you know, we are coming before you, because of a sustained decline in our inpatient demand and our outpatient clinic patient panel being a small volume, and it does not lend itself to the expanded access that we think our patients deserve.

So our secondary concern is really that our inpatient service is something that has changed dramatically over the last couple of decades.

This is not unique to the Hospital of Central Connecticut. Nationally, what we have seen over the last, you know, two decades ago, since I started my training, things are very different in the landscape of pediatrics.

Again, like when I started my training a couple of decades ago, it was very common for patients to be admitted to the hospital for low complexity type conditions.

Those patients are not something we really see as often anymore coming into the hospital. We have

had much success in a lot of our treatments in pediatrics, which, of course, is great, but it has decreased the number of patients that we're seeing in the hospital.

Examples of that would be things that we are now treating with vaccines. So, again, when I first started training, we used to see pneumococcal disease very commonly. Excuse this, but diarrhea admissions used to be very common for children and other vaccine preventable diseases that we would see, especially in the infant population, which now have, you know, are not something we really see anymore, or are very well-managed as outpatient.

The common diseases that we've seen that used to be the bulk of our inpatient admissions are really not there anymore. Not that that's a bad thing, but it's just changed what we see in the hospital.

The last decade or so, the research has shown that the patients that are being admitted to the hospital now are much more complex. They are mostly patients that have chronic conditions, patients that have other comorbidities with their condition that require subspecialists, and these are not the type of patients that we typically had taken care of in the community

hospital environment.

Again, we do have the capabilities in the community hospital environment to see low-complexity patients, but those are not really the patients that are, you know, that are out there anymore.

The patients that are being admitted to the hospital are patients, again, with chronic illnesses, and most of those do need subspecialty support, so things like pediatric cardiologists, pediatric pulmonologists, specialty testing, radiologists that specialize in pediatrics, a lot of the things that can be offered in a children's hospital environment, specialists related to pediatric therapies, things that we are not equipped to provide.

So, for those patients, when they are with us, we would have to consider whether we are able to give them the care that they really need or if they are better cared for in an environment, where they can reach those specialists.

As far as our outpatient clinic, which, again, is part of this proposal, what we have seen is that our clinic panel has come to a point, where it is really the number of patients we see per year is really a little bit less than the typical panel for one

pediatrician, so we do have one pediatrician that cares for those patients, but having one pediatrician does not lend us the opportunity to have expanded hours for our patients, so evening hours, weekend hours, the nighttime call that we sometimes get from parents, we're not able to provide that expanded breath of coverage with just one physician, so we have not seen, you know, a growth there that would allow an expansion of that process, and we do feel there's a bit of restriction to our patients in the services that they can get off hours.

One of the things that we are, you know, have to resort to for our patients in that instance is, you know, if they need something at night that can't be handled by our triage service, they are directed to the emergency room, or, you know, on a weekend or holiday, as opposed to having the opportunity to be seen in the office environment, which is typical of many community practices for pediatrics.

So we really feel as though some of the things that we're doing right now are not cost effective, which is something we're certainly required to do.

We're not able to provide our services in the most efficient and coordinated fashion for these children, and, you know, we are in a situation, where

some of our services are underutilized, and we certainly don't want that, as well.

So, you know, one of the things that we're trying to improve is the quality and access for these patients, so we want to make sure, if they require inpatient care, that they do have access to specialists and specialty services, which we don't have.

We want to make sure that our outpatients have access to broader hours, in terms of office visits, as opposed to accessing our ED unnecessarily.

We want to make sure that, in the off hours, when our patients call for questions, that they are able to reach their doctor or their physician partners, so that they can have access to their records, and they can coordinate their care, you know, 24 hours a day, as opposed to some of the interruption that we have now with a patient going to the emergency room and those physicians not necessarily being primarily familiar with our patient, so there are other offices that they can access that will have services available on the weekends and evenings and holidays.

We do, again, want to make sure that we're able to coordinate their care as best we can. Right now, when we require subspecialty services for our patients,

that's mostly accessed over the phone, so we do call subspecialists if we need them, and if the case can be handled over the phone, we do that, and then try to arrange for follow-up, but sometimes it does require transfer of a patient if they need a subspecialist that's not available in our institution, so we definitely want to decrease that, as well.

And we want to make sure that the patients do have an opportunity to choose services that would provide those off hours' care in a more coordinated fashion than we can.

It's certainly not something that, you know, we -- you know, as a pediatrician, I actually became a hospital-based pediatrician myself, because I really enjoy taking care of the sickest of the kids when I was, you know, during my training, and that group of patients has narrowed down tremendously over the last 20 years.

Again, as someone, who cares for children, that's not something that I can say I'm upset about. We certainly want to see less children in the hospital and less children needing that kind of service, so we've done, you know, a great deal of good by changing that pattern, but, with that pattern changing, it has to

change what we do, in terms of our staffing and how we use our physicians and use the resources that we have and adjust to what's, you know, the new health care environment that we're in.

So we do plan, you know, if we have approval with this, to make sure that we transition our patients appropriately. You have, in our application, a transition plan that we have worked on that we will make sure is in place to provide the patients with the best access that we can that's their choice, as well.

HEARING OFFICER HANSTED: Thank you, Doctor. Do you have anything further, counsel?

MS. FELDMAN: Yes. This is Joan Feldman with Shipman & Goodwin on behalf of the Applicant, the Hospital of Central Connecticut.

I just wanted to basically try to summarize the reason why we're here today. The hospital has made significant efforts and made significant financial and resource investment in trying to sustain and build a pediatric inpatient and outpatient program.

And as we describe in our application with respect to the inpatients, we essentially have no census. There's no demand for our inpatient pediatric beds, and that's for the reasons that the doctor has just

explained.

It's also, in part, due to the preference of some of our community physicians preferring to have their patients admitted to a specialty children's hospital or a hospital that has a higher census and is going to insure staff with high-level competencies and experience.

So despite the efforts that we made to make the inpatient unit more attractive by having two hospitalists, there really weren't patients for these hospitalists to take care of. They were basically sitting around like the Maytag repairman, waiting for patients to come in that they could care for.

Obviously, that was not good for them, and it didn't make much sense from a resource allocation on behalf of the hospital.

That's not to say that we're not willing or aren't currently willing to accept inpatients. We still have maybe two or three a year, but it's just not an ideal situation, and I think anybody that has children would probably want their child to be in a hospital, where it's fully staffed and has all the backup and expertise that's necessary.

With respect to our outpatient clinic, you

know, as the doctor explained, the census in the outpatient clinic is very low. When we submitted our application, we said we had about 1,200 patients at that time, and it's dropping. It continues to drop.

As of, you know, now, it's probably down to 1,000. We have one full-time pediatrician, who, as we stated in the application, is planning on going into private practice, and she has already been contacting patients and making arrangements to transition most of these patients to her private practice.

In addition, we have been talking to the Community Health Center and have agreed to make a commitment, should OHCA approve this application, to allow the transition of some of these outpatients that were currently being seen at the hospital to CHC, where they'll have a full complement of services available to them and 24/7, 365-day-a-year coverage.

So that is why we're here today, and we're happy to answer any questions you may have.

HEARING OFFICER HANSTED: Okay, thank you, counsel. We do have some questions. Jack, did you want to start, or Karen?

MR. HUBER: Sure. Jack Huber for the record. We'd like to begin our line of questioning with

some questions regarding the inpatient component.

In the application, the hospital indicates that the annualized number of pediatric discharges will be zero for FY 2015. Now that this fiscal year has concluded, what was the actual number of inpatient pediatric discharges, other than maternity and newborn, for the hospital?

DR. GOLIOTO: It's zero.

MR. HUBER: It's still zero.

HEARING OFFICER HANSTED: You've had none for fiscal year 2015?

DR. GOLIOTO: No pediatric medical patients, no.

HEARING OFFICER HANSTED: Okay. Have you had any pediatric patients present at the hospital and be referred out during that time, or has no one presented for services?

MS. FELDMAN: May I clarify? Are you asking presenting to the emergency department?

HEARING OFFICER HANSTED: Well presenting either to the emergency that would need inpatient or to the clinic.

DR. GOLIOTO: To the clinic, I'm not aware of any.

HEARING OFFICER HANSTED: Okay.

DR. GOLIOTO: To the emergency department, yes.

HEARING OFFICER HANSTED: Okay and do you know, do you have any idea of how many that would be? If you don't know that off the top of your head, that's fine. We can get that as a late file.

DR. GOLIOTO: Okay.

HEARING OFFICER HANSTED: Okay, why don't you -- you have not been sworn in. If you just want to be sworn in?

DR. ANAND SEKARAN: Sure.

COURT REPORTER: Would you mind coming closer to the mike over here?

DR. SEKARAN: Sure.

HEARING OFFICER HANSTED: Have a seat up here. Why don't you stand and raise your right hand, and the court reporter will swear you in?

(Whereupon, Dr. Anand Sekaran was duly sworn in.)

HEARING OFFICER HANSTED: Thank you. Okay, so, the question was with regard to patients presenting at the emergency room needing inpatient admittance. I'll use that term if it's applicable.

Do you know the number of patients in fiscal year 2015?

DR. SEKARAN: Maybe I'll introduce myself first.

HEARING OFFICER HANSTED: Sure.

DR. SEKARAN: So everyone knows who I am. So sorry for the late arrival.

HEARING OFFICER HANSTED: That's okay.

DR. SEKARAN: So my name is Anand Sekaran, and I am going to be speaking later, but, just very quickly, I'm the Medical Director for the inpatient services at Connecticut Children's Medical Center, which has been the primary recipient of the inpatients, who need, you know, hospitalization, sent from the New Britain ED, Emergency Department.

So we actually, on an unrelated note, we're looking into the number of transfers we get from other hospitals, and it's data that I have that shows from New Britain Emergency Department admitted to Connecticut Children's. I have a number of 205, and that's for not exactly fiscal year.

We tracked it from January 2015 to October 2015, so that's 205 patients, who presented to the New Britain HOCC Emergency Department, required inpatient

hospitalization, and were then transferred to Connecticut Children's.

HEARING OFFICER HANSTED: Okay, now, just to follow-up, back to the Applicant, were those patients that were not appropriate to be admitted to the hospital? Why were they sent to Connecticut Children's Medical Center?

DR. GOLIOTO: So I have my estimate is I think our number is more, but that's not for the whole fiscal year, but, for the whole fiscal year, around 311 patients transferred from the New Britain ED to Connecticut Children's for inpatient admission, as best of my knowledge.

We have always had patients that are transferred if their care is not, you know, not appropriate for the Hospital of Central Connecticut, so that is not, you know, that is not particularly unusual, but the transfer is necessary if the patient's pediatrician chooses not to, you know, admit them, or their complexity of their care requires them to be at Connecticut Children's.

HEARING OFFICER HANSTED: Okay, so, for fiscal year 2015, that was the case with all the patients presenting to the ED?

DR. GOLIOTO: That's correct.

HEARING OFFICER HANSTED: Okay, thank you.

MS. FELDMAN: Attorney Hansted?

HEARING OFFICER HANSTED: Yes?

MS. FELDMAN: This is Joan Feldman. I would just like to add to that to respond more specifically to your question about why are patients that present to the ED at HOCC not admitted as inpatients to HOCC? There's multiple reasons why.

HEARING OFFICER HANSTED: Right.

MS. FELDMAN: One is complexity, but the major issue is, if community pediatricians don't want to care for their patients once they're inpatients, which is the case in our community, and that is the reason, in part, why we hire hospitalists, but couldn't sustain them, then there's nobody to care for that patient when they're an inpatient.

The few admissions that we have had over the last few years tended to be surgical admissions for very uncomplicated surgeries involving children ages 13 and over.

HEARING OFFICER HANSTED: Okay, thank you, counsel. I'll digress from that question. Mr. Huber, sorry to interrupt.

MR. HUBER: That's okay. In your testimony this evening, you've provided us with factors that have led to the decrease that has been experienced in pediatric discharges.

Could you please elaborate on the rationale, as to why the hospital chose to undertake the hospitalist program in 2012?

DR. GOLIOTO: I can. So I was not part of that, but at the time that that occurred, we were seeing a decrease in the inpatient admissions and, also, the decreased willingness of physicians out in the community to care for patients in the hospital arena.

Hospital medicine has really changed dramatically, both for adults and pediatricians, in that hospital medicine, in and of itself, is becoming its own specialty, that there are physicians, who only specialize in taking care of inpatients, so it's not uncommon that physicians, who primarily do outpatient medicine, this becomes less of something that they want to do.

So the thought was, bringing on hospitalists to do this, would potentially be an attractive program that people would possibly refer patients to be admitted with the hospitalists there, and that also our own community would feel comfortable

admitting these patients to the hospital service.

The potential there was to sustain and possibly grow the service with the addition of the hospitalists.

MR. HUBER: Thank you. In the CON application, you provided us with a copy of the latest emergency patient transfer agreement with Connecticut Children's Medical Center.

How long has the transfer agreement between the two hospitals been in existence?

DR. GOLIOTO: So we have always transferred patients to Connecticut Children's Medical Center, however, this particular one that was supplied with our application was for fiscal year '15, was created in fiscal year '15.

MS. LUCILLE JANATKA: Lucille Janatka.

HEARING OFFICER HANSTED: If you could just come up to the microphone, please? Thank you.

MS. JANATKA: Lucille Janatka. This is a very common agreement to have in community hospitals. I don't know the number of years that it's been place, but my guess would be that it's probably been in place more than five years, because of the nature, as our physician just explained, of children that present and the

complications that they incur, so this is very common. It's been in place a long time.

If you do need to know that, I'll do the research to find out.

MR. HUBER: The impression, I guess, in reviewing the application, it's been in existence for more than just one cycle.

MS. JANATKA: Oh, definitely.

MR. HUBER: It goes back several years.

MS. FELDMAN: Joan Feldman again. We asked our Medical Director for the Emergency Department to be present to answer any questions you might have.

DR. DAVID BONO: Hi. Dr. David Bono, Chief of Emergency Medicine, Hospital of Central Connecticut.

Going back to the inception of Children's Medical Center, we've always had not a written agreement, but there's always been a policy that if we needed their services, because we couldn't care for children in our either Emergency Department or in the hospital, we would transfer to a higher level of care, so that has been from day one of the hospital opening up that we've transferred children to Connecticut Children's if they needed a level of care that we could not provide.

HEARING OFFICER HANSTED: Okay, thank you, Doctor.

MR. HUBER: Have you sought such an agreement with any other area providers?

MS. JANATKA: Not for inpatient care.

HEARING OFFICER HANSTED: Is there any reason for that, or it just hasn't occurred to seek out another alternative?

MS. JANATKA: They're so close. I mean it really is very convenient for our community and for families to go to Connecticut Children's. That would be my guess.

DR. GOLIOTO: No, I agree. I mean most of the time, for most of the patients that present to our emergency room, the proximity for them would be better to go to Hartford to Connecticut Children's.

If they requested something different, then we would honor that, of course.

HEARING OFFICER HANSTED: What would happen if you had an epidemic, where Connecticut Children's Medical Center was at capacity and you had patients that needed to be transferred out? What would happen then?

Do you have the ability to send them to

let's say St. Francis for care?

DR. BONO: We do that now for any hospital for even adults. If a hospital that we want to transfer to is full, we go to the next hospital, so there's Yale. Any other hospital accepting pediatric inpatients we would call for availability and transfer.

HEARING OFFICER HANSTED: Okay, so, you don't necessarily need a transfer agreement?

DR. BONO: No.

MS. FELDMAN: No.

HEARING OFFICER HANSTED: Okay.

DR. BONO: We just need an accepting physician on the other end.

HEARING OFFICER HANSTED: Right. Okay, thank you.

MR. HUBER: Section four of the transfer agreement appearing on page 73 of the application is entitled Performance Improvement, Education and Research.

The section, in part, states, "The parties shall jointly participate in transfer review conferences and morbidity and mortality conferences relating to such transfers." How often does each of these conferences meet?

MS. FELDMAN: Okay. Joan Feldman. Mr.

Huber, just let me sort of give you some context of that provision and where it stems from.

MR. HUBER: Sure.

MS. FELDMAN: You often see that kind of provision in agreements between hospitals, where patients are being transferred back and forth, and it's something that the Joint Commission generally likes to see, that there's some sort of accountability between the hospitals, and that typically occurs between the pediatricians at CCMC and the pediatricians, who the patient is being referred back to, in terms of the care of the child, but in terms of communications between our Director of the Emergency Department and the Director of the Emergency Department at the Children's Hospital, that happens on a regular ongoing basis.

To the extent that we have neonates being transferred between the two hospitals, there are formal meetings that take place twice a year between our Chief of Pediatrics and her counterpart at CCMC with respect to transfers.

MR. HUBER: Now do these meetings produce any performance improvements?

DR. GOLIOTO: Sure. So I undertake, two times a year, meetings with my counterpart at the

Connecticut Children's Medical Center to review all of our neonatal cases that are transferred, and we do identify if there are any areas of improvement that could have come from the care that we provided. We do identify those and plan accordingly for any ongoing improvements that we need to do.

MR. HUBER: In an earlier response, you identified the Joint Commission on Accreditation. Is there anything, document-wise, that you have to provide them if they come to do a review with the hospital with respect to these type of meetings from a quality point of view?

MS. FELDMAN: Not that I'm aware from a standard perspective, that there's any requirement to have any kind of written documentation to reflect that.

You know, one of the things that we're hoping we'll accomplish if this application is approved is that there will be less transfers between our ED and the Children's Hospital, in that, you know, we think that, if children have their pediatricians caring for them in the community, either private practices or CHC, children will be going and seeing their clinicians rather than presenting to the Emergency Department.

And if there is a decision that is made,

that the patient needs inpatient admission, it will be made directly to CCMC, as opposed to by way of HOCC.

MR. HUBER: This is the last question in this line. Are there any educational research activities that have been undertaken by either of the committees that you can point to?

MS. FELDMAN: Can you restate the question, Mr. Huber?

MR. HUBER: Yeah. With respect to the Transfer Review Committee and the Morbidity and Mortality Conference, what type of educational and research activities have been undertaken by these committees, and, if there have been any, what results have they achieved?

DR. GOLIOTO: So for the conferences that I hold twice a year in regard to the newborns, we actually expand the invitation to those conferences to all of our neonatologists, our APRN counterparts in newborn care.

We actually opened it up to our partners at MidState and our mid-level practitioners at the Hospital of Central Connecticut, and we do actually do this as an educational activity, and I do keep records of those presentations.

MR. HUBER: Thank you. That's all the

questions I have for the moment.

MS. KAREN ROBERTS: Karen Roberts, OHCA staff. Utilizing HOCC's inpatient discharge data submitted into OHCA's acute care hospital inpatient discharge database, for FY 2014, it appears there were 70 respiratory discharges for patients from New Britain and Southington, the two primary service area towns, for patients age six months to 17.

The majority of those from the discharge data appear to be from the bronchitis and asthma DRGs, DRGs 202 and 203, so that was for FY '14. Have there been any pediatric respiratory admissions for FY '15?

DR. GOLIOTO: So, for pediatric, we have not had any. We have had very, very few. I mean I would say maybe one or two neonatal admissions, which we have admitted to the newborn intensive care unit.

MS. ROBERTS: So how does not having any in FY '15 compare to having approximately 70 respiratory pediatric the year before? That seems to be quite a big difference.

MS. FELDMAN: Yes, and I think that it's not that necessarily the incidents declined that dramatically, despite all the advances the doctor described. It's simply that it coincides with the fact

that our hospitalist program came to an end, and community pediatricians do not desire to have to care for their patients when they're inpatients. If they admit them to CCMC, they don't have to go in and see them, and they know their patients will be well taken care of, so it really is contemporaneous with the end of the hospitalist program.

MS. ROBERTS: Okay. In the hospital's 2015 community health needs assessment for the HOCC service area, there's an emphasis on asthma, including childhood asthma.

First, I'd like to enter into the record as OHCA Exhibit 1 the full copy of the HOCC 2015 community health needs assessment, which was accessed through the hospital's website at THOCC.org.

It appears, from the community health needs assessment, that respiratory disease, including children's asthma, prevalence is considered an area of opportunity, and respiratory disease is listed as number seven on the prioritized list of community health needs.

Can you explain how access to pediatric inpatient and clinic level asthma care will be maintained or improved and what HOCC's role will be in pediatric asthma care in the New Britain area going forward?

DR. GOLIOTO: So, in regard to asthma, one of the articles that actually we submitted with our application particularly describes that, over the last decade or so, the rate of pediatric inpatient admissions for asthma has actually decreased about 20 percent, and the pediatric asthma admissions that are occurring, which still clearly are out there, are often combined with comorbidities, so these are not often simple patients that have asthma, but they have something else, besides asthma, that makes them a more complicated patient, and it's, therefore, requiring the assistance of subspecialists to take care of them.

So where most general pediatricians have done very well with taking care of patients in the past in the hospital, those that are sick enough to require asthma admission are really a different type of patient.

Pediatric asthma has become a very controllable disease in the outpatient setting, and our pediatricians that are in the New Britain area certainly do a great job in taking care of these patients as outpatients, but when they're admitted, it is often that they need subspecialists that we are not able to provide.

MS. ROBERTS: With respect to the hospital's ongoing commitment to addressing that need in

the community, that will remain unchanged. That is part of the community needs health assessment, and that commitment to funding whatever programs are currently funded will continue, including the efforts in the funding that is described with respect to CHC?

MS. FELDMAN: Lucille, do you want to?

MS. JANATKA: I guess I would just say that -- this is Lucille Janatka. That, with our community needs assessment, we are actively working right now, including our Board members, with our physicians in our community to have an action plan to address the areas of that assessment, and, certainly, asthma will be a part of it, and we will continue to fund and to support programs and educational opportunities for many of the points that have been made in the community needs assessment. I think you mentioned asthma was number seven.

MS. ROBERTS: Yeah.

MS. JANATKA: There are six above it that we're also very involved in, as well.

HEARING OFFICER HANSTED: What programs are currently funded by the hospital?

MS. JANATKA: I would have to turn to maybe my clinical staff or administrative staff.

HEARING OFFICER HANSTED: If you could come? Do you know who will be able to answer that?

MS. JANATKA: Does anyone know? No.

HEARING OFFICER HANSTED: Okay.

MS. JANATKA: Okay. We'd have to look that up for you, if you would like.

HEARING OFFICER HANSTED: Okay.

MS. FELDMAN: This is Joan Feldman again. As you can see from the community needs assessment, it's a very recent one. We would have to go and see what our last few community needs assessments identified as needs, and we could report back what we did in response to those identified needs.

HEARING OFFICER HANSTED: Well what I'd like to know is you're testifying that you will continue to support these programs you have been supporting. I want to know what those programs are.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: Specifically what the programs are, so if you could provide me that list? How long do you think you need for that?

MS. FELDMAN: A week.

HEARING OFFICER HANSTED: Okay. If you could? Let's see. What's today? It's the 2nd. That

would be by December 9th, and that will be Late File No. 1.

MS. FELDMAN: And just to clarify and confirm for you, Attorney Hansted, to the extent that our community needs assessment has identified a pediatric health need, the fact that we don't have an inpatient or outpatient program does not preclude us from identifying that as a need in the community and addressing it.

HEARING OFFICER HANSTED: Absolutely.

MS. ROBERTS: Just to clarify, when you say fund, support, or educate, that doesn't sound like programs that the hospital actually provides, the hospital funds or supports, is that correct, versus actually being the provider?

MS. JANATKA: It varies. I mean it may be educational opportunities in the community. It may be working with clinical staff in a community arena. It's a variety of things that we're involved in.

MS. ROBERTS: Thank you. Doctor, on page four of the pre-file that was submitted, you indicate, and you talked about this earlier, too, I believe, that currently during after-business hours clinic patients, or their parents in this case, can call an outsource nurse triage system, and that system may direct a patient or

the parent to go to the HOCC ED for care.

So that system is pediatric-specific, and it's related to the clinic, itself?

DR. GOLIOTO: Yes, that's correct.

MS. ROBERTS: Okay, so, after the clinic closes, that triage, that nurse triage system will or will not continue?

DR. GOLIOTO: So after the clinic closes, that nurse triage system will no longer be in place. That's specifically for the patients that come to our outpatient facility, and most every community, you know, pediatric group has something of this sort to support their patients, so we would imagine that they would then have that support with their new provider.

MS. ROBERTS: And the triage system will continue through the entire transition period?

DR. GOLIOTO: Correct.

MS. ROBERTS: This is financial related. If the triage system, which I assume costs money, isn't going to continue, it doesn't appear that there's a reduction in this outsourced expense included in the financial projection. Is this an expense currently, and, if it's going to discontinue, why wouldn't it have been in the financials?

DR. GOLIOTO: So there is an expense. It is not a tremendous amount of money. I believe we pay about $17 per call, and we usually have a monthly bill that is in the range of $300 or $400.

HEARING OFFICER HANSTED: So this is a service that's subcontracted out? It's not a nurse at the hospital?

DR. GOLIOTO: No.

HEARING OFFICER HANSTED: Okay.

DR. GOLIOTO: That's correct.

MS. ROBERTS: So by not including it in the financial projections going forward, it's because it's minor, a very minor expense that was just based on the number of calls?

DR. GOLIOTO: Um-hum.

MS. ROBERTS: On page six of the pre-file that you had submitted, you indicate that the other community providers can offer the enhanced after-hours coverage, so that when there are after-hours needs, these families do not have to resort to the ED to be seen.

Looking at Table 9, it was revised in the completeness responses on page 134, where you list all the other providers and their hours and days of operation, the hours and days of operations for most of

these providers, except for the Community Health Center, which has regular Saturday hours, are typical office hours during the week much like the HOCC clinic, so, in light of that, can you explain how these alternative sites will provide enhanced after-hours access to services and how this will be an improvement in accessibility for the clinic patients?

DR. GOLIOTO: Sure. So, as you mentioned, CHC does have evening hours and Saturday hours. Our two private practices that are in the New Britain community also have weekend hours, as well, but they're by appointment, so they're not necessarily listed as regular hours, but the difference, also, that patients will see is that, in the evening, when they call, they will often reach their physician or one of their physician partners, that, in many cases, also has access to the patient chart, even when the office is closed, and that would allow them, you know, a little bit more familiarity with the patient and what their situation is and what kind of care can be advised at that time, as opposed to perhaps sending the patient to the Emergency Department, and can have a little bit better feel for whether that patient can be managed overnight and see the physician in the morning or advise other directions.

MS. FELDMAN: This is Joan Feldman again. Just to clarify, when you are cared for by a community pediatrician or by CHC, there is 24/7 coverage call, so if at 2:00 in the morning you have a baby with a fever, you call the office, and you get an answering service typically, and the doctor will call back, and that is what we meant by enhanced coverage.

MS. ROBERTS: So with the HOCC clinic, the triage, it's a nurse answering, and you wouldn't get back a call from the doctor that staffs it?

MS. FELDMAN: The nurse would be handling any and all calls, so the nurse, I would say, handles probably 95 percent of the calls, and a few of those calls come through to one of the pediatric providers at the hospital, which are pediatric physician assistants and the neonatologists that are on staff, and if we can address the call appropriately, we do, otherwise, we also may need to direct the patient to the Emergency Department.

MS. ROBERTS: That's also 24/7, though, isn't it? In saying that the others are 24/7, Community Health Center, this would also occur 24/7 currently?

DR. GOLIOTO: It does, yes, but these are not -- this is not, you know, if they call me, it's not

my regular patient, so, in terms of my familiarity and what I can advise is different than potentially calling their own physician.

MS. FELDMAN: Correct, and the nurses respond, pursuant to standard like standing orders and protocol. It's not, you know, it's not ideal, and I think that most parents with a sick child would prefer to speak to their child's pediatrician than speak to a nurse, but this is how we basically piece together what is very difficult to obtain, in terms of coverage, because we only have one pediatrician for a very small panel of patients.

HEARING OFFICER HANSTED: Let me ask you this, Doctor. If you could walk me through two scenarios? If the clinic and the inpatient program were to close, the first scenario is a child that needs services after hours and -- well let's start with that one. That's the first scenario you have, a parent, who calls -- who would they call? Would they call the primary physician and lead me through there?

DR. GOLIOTO: So, typically, you know, any of us that have a child that would be sick in the evening would call our patients' pediatric office, and then, depending on what is setup in their office, they perhaps

would go first through a nurse triage system and/or straight to one of the physicians or mid-level practitioners that staff that office, and depending on what the parent is calling for, they may be given some advice that would say, you know, do this, and call me back in a couple of hours, or go to the emergency room, you know, if this is something that's urgent.

Occasionally, there are physicians that will direct the patient to the office to see them in off hours, but, for the most part, they would have that scenario, where they would call their doctor's office and get the answering service and then get the advice to either, you know, do some type of intervention overnight and be seen in the morning, or to go to the emergency room.

HEARING OFFICER HANSTED: Okay and the second scenario would be a child presents at your ED. What happens then?

DR. BONO: Dr. Bono. I mean, when they come to the ED, we see them and evaluate them and provide the necessary treatment like we normally would.

HEARING OFFICER HANSTED: Okay and then, if they needed to be admitted as an inpatient, what would happen?

DR. BONO: This is if the --

HEARING OFFICER HANSTED: Assuming --

DR. BONO: -- there's no pediatrics.

HEARING OFFICER HANSTED: Right.

DR. BONO: We would do pretty much like we've been doing. We would call over to Children's Hospital. Well I should say that now I would call the primary physician, and what they would do (interruption in microphone) so I would just call over to the Children's ED, talk to the ED physician there, get an accepting physician, and we would arrange for transfer from our ED to (interruption in microphone).

HEARING OFFICER HANSTED: Thank you.

MS. ROBERTS: My next question is regarding the statement that's made on page seven of your pre-filed testimony, which states that "Community providers are more likely to send the child directly to CCMC's ED."

Actually, the whole sentence is that, "Should their community providers feel their patients need inpatient admission, the community providers are more likely to send the child directly to CCMC's ED."

Has this change in pediatric ED visits already been occurring now or have the pediatric ED

visits dropped, the volume dropped in recent past, because of this?

DR. BONO: Our ED volumes seem to be the same. I have not noticed a difference in volumes.

MS. ROBERTS: Would you expect that the ED visits are going to drop?

DR. BONO: Not significantly, only because the vast majority of the children we see do not need admission. It's a small percentage, who need admission.

MS. FELDMAN: But, again, the children that come to the ED may or may not be patients of the clinic, number one. Number two, if they are patients of the clinic, they may be coming to the ED, pursuant to the nurse triage direction, and we seem to believe that, once we have a firm plan, so everybody knows who is providing what services in the community, and, certainly, there is a wealth of pediatric providers in the community that we hope that, for instance, the children that are patients of CHC will learn and be educated that the ED is not the most ideal place for them to go, but that they can call CHC and get, you know, get seen, or get advice. Doctor?

HEARING OFFICER HANSTED: You can just keep that there.

MS. JANATKA: Okay.

DR. SEKARAN: So just to comment on the medical aspects of that topic, from a medical perspective, it's far more advisable to have a child sent to one place rather than sent to -- you know, if one thinks, if the primary care provider thinks that this is likely to end up in an admission to the hospital, an example would be a 20-day-old with a fever, every single one gets admitted, so it's far preferable to send the child and family to one location rather than go to an ED, get evaluated, and then be put into an ambulance with all the risk that that entails, and then be sent to Connecticut Children's.

So if one can, in any way, predict that this is likely to be an admission, medically, it's preferable to not have to do two transports.

HEARING OFFICER HANSTED: Is it possible to predict whether or not it will lead to an admission?

DR. SEKARAN: In many cases, yes, based on protocols almost. As I said, every baby under 28 days of age, who develops a fever of 100.4 or greater in Fahrenheit, will be admitted to the hospital.

Another example would be, again, young babies with bronchiolitis, what we referred to earlier, is a lung infection, very common viral lung infection, if

that baby is in distress and less than a month old, so it's really the extremes of age in health care that we worry the most about the young babies. We typically will know when they need admission.

HEARING OFFICER HANSTED: Okay and just to follow-up on that, and any of the doctors can answer this, let's say, you know, my child has asthma, and I just called 9-1-1, and the ambulance shows up at my house, where does that ambulance go?

Is that ambulance directed to CCMC, because they know it will be admitted, or could they potentially end up at HOCC and have to then be transferred again to CCMC?

DR. BONO: I can answer that. If the EMS, when they show up and evaluate the patient, if they feel that patient can safely go to CCMC if they have a relationship there already and the family requests it, they will take them directly to CCMC, so they'll provide treatment for the asthma on route and take them directly to CCMC by request.

Now if that patient is highly unstable and they feel they need something right away, they, by protocol, will go to the nearest hospital.

HEARING OFFICER HANSTED: Okay.

DR. BONO: But they do have that option to go to --

HEARING OFFICER HANSTED: So there's potential that a patient would be admitted to your ED and then have to be transferred to CCMC for an inpatient or even to CCMC's ED?

DR. BONO: Absolutely.

HEARING OFFICER HANSTED: Okay, so, if that happens, are there two ED charges for that patient?

MS. FELDMAN: If the child gets admitted as an inpatient to the second hospital, CCMC, they will not, as I understand --

DR. GOLIOTO: If it's direct admission.

MS. FELDMAN: Not even if it's a direct admission.

DR. GOLIOTO: From the ED.

MS. FELDMAN: If it's a direct admission from the ED, there will not be payment for the second ED visit by the payer.

HEARING OFFICER HANSTED: If there's a direct admission from CCMC's ED?

MR. HUBER: Correct.

HEARING OFFICER HANSTED: There will be no ED charge?

MS. FELDMAN: At least that's the rule for Medicaid.

HEARING OFFICER HANSTED: What about non-Medicaid?

MS. FELDMAN: I really --

HEARING OFFICER HANSTED: I mean there's private pay insurers out there.

MS. FELDMAN: No, I understand that. I will say, though, that this is very largely a Medicaid population we're speaking about, but I don't feel I can speak to every plan.

HEARING OFFICER HANSTED: Is there anyone that can speak to that, I mean the doctors or anyone? Come on down.

COURT REPORTER: I can probably hear from here.

HEARING OFFICER HANSTED: You can hear? Okay. Were you sworn in earlier?

MS. CAROLYN FREIHEIT: Yes, I was.

HEARING OFFICER HANSTED: Okay, thank you.

MS. FREIHEIT: My name is Carolyn Freiheit. I'm the Regional Vice President of Finance for the Hospital of Central Connecticut.

So the population that we're speaking

about, yes, is primarily Medicaid. In the case of private insurers, when a patient comes to an Emergency Department and then ends up getting admitted to that same organization, it's one encounter, so the organization gets paid for one of them, and that is usually the inpatient stay, so it's not like the payer is paying for two visits at that entity.

In this example that we're speaking of, when the patient comes to the Emergency Department and then has to be transferred, then there is potential for two payments to be made if it's deemed medically necessary.

MS. ROBERTS: But going back to whether there's going to be a reduction in ED visits at HOCC, the scenario of pediatricians in the area deciding to send their patients, telling their patients or their parents to bring the child to the CCMC ED, because they think they're going to be admitted or they've just gotten into the use of CCMC, it seems like there should be an expected reduction in ED visits, however, that wasn't projected in the financials.

Is it likely that there will be some volume reduction related to this CON specific to the ED?

MS. FELDMAN: I think we have to ask that

question to Carolyn.

MS. FREIHEIT: I'm sorry. Could you repeat the question?

MS. ROBERTS: With the scenario going forward, if there's an approval and the clinic closes and there's no inpatient admissions, is it likely that there will be a reduction in ED visits, and, if there will be, why wasn't it included in the financial projections?

MS. FREIHEIT: It's highly unpredictable, and the volume reduction was felt to be small.

MS. ROBERTS: Will this CON change any of the protocols or competencies for handling pediatric patients in the ED?

DR. BONO: No, nothing will change.

MS. ROBERTS: The staff competencies for handling all ED visits will continue?

DR. BONO: Correct. We do that at present, and we always will.

MS. ROBERTS: Does HOCC have a large volume in the ED of the ED visits for emergency psych crisis evals? Is that a large bulk?

DR. BONO: Not a large number, no.

MS. FELDMAN: Are you talking about children, specifically?

MS. ROBERTS: Pediatric, yeah, emergency psych crisis evals.

MS. FELDMAN: No.

DR. BONO: No. Most of it is medical.

MS. ROBERTS: Okay. Regarding the impact or possible impact of the closure of the inpatient program might have on pediatric surgery, the hospital indicated in the pre-file that HOCC doesn't have a specific pediatric surgical program, and it sounds like the age 13 keeps getting mentioned, I think. Is surgery under age 13 not done at HOCC?

DR. GOLIOTO: Inpatient surgery, generally no. We want to make sure that our surgeons, who are not specifically pediatric trained, feel comfortable with the patients certainly that they're accepting, so they accept patients. It's their decision to accept a patient for surgery.

It usually is a very non-complicated patient, again, making sure that there's no comorbidities that would require a pediatric subspecialist and that it is a relatively grown patient that they would be operating on, so, yes, usually teenagers.

MS. ROBERTS: So regularly-scheduled surgery, not likely any that have the potential for being

complex or have any possibility of inpatient admission as a result?

DR. GOLIOTO: That's correct.

MS. ROBERTS: So there also is no projected or estimated impact on the volume for those kinds of surgeries, is that correct?

DR. GOLIOTO: Right. The surgeries that we do today the surgeons would still choose to do, so there really shouldn't be a significant impact on the surgeries that we do.

MS. ROBERTS: And pediatric surgery competencies will remain?

DR. GOLIOTO: Yes.

MS. ROBERTS: Okay. Jack?

MR. HUBER: I have a couple of questions regarding outpatient services, and then a couple of questions, financial questions.

Forgive me for asking this question, because I believe you may have already responded to it, but I didn't quite get the full effect of what you were speaking about.

You indicated that, in terms of outpatient, and I'm not sure whether it's visits or the patient, number of patients, there was a 1,000 number you

provided.

MS. FELDMAN: Right.

MR. HUBER: And that was relative to?

MS. FELDMAN: That's the patients.

MR. HUBER: Patients. So you've seen a reduction from the 1,200 that you mentioned in the application to 1,000?

DR. GOLIOTO: Roughly, yes.

MR. HUBER: My next question is just a quick follow-up. Doctor, in your testimony regarding the outpatient pediatric clinic, indicates that the remaining outpatient pediatrician will be leaving her hospital position within the next few months.

Should the proposal be approved and the current pediatrician departs the clinic, what arrangements will be made to provide physician coverage at the clinic during the six-month transitional period prior to the clinic's closure?

DR. GOLIOTO: So we actually have already secured locum tenens coverage for our clinic to begin after the departure of our current pediatrician.

HEARING OFFICER HANSTED: What coverage was that?

DR. GOLIOTO: Sorry. That is kind of a

per diem type position, but we either usually secure them for you can do three months, six months, etcetera.

HEARING OFFICER HANSTED: Okay.

DR. GOLIOTO: It's pediatricians that are available in the community that can do the work.

HEARING OFFICER HANSTED: Okay, thank you.

MR. HUBER: Prior to the hearing, I conveyed a spreadsheet that we would like to have filled out and submitted to us as a late file. It would be Late File Submission No. 2, consisting of two spreadsheets that address in a three-year fiscal retrospective the inpatient pediatric and outpatient pediatric services financials individually for the period covering fiscal years 2013 through 2015.

The format of that information for this late file will be provided to you electronically, so that it can be collected more easily and on a paper form.

HEARING OFFICER HANSTED: So I'll order that as Late File No, 2, and, as Mr. Huber said, we'll notify you electronically. We'll state again in the e-mail what exactly the late file is and provide the format.

MR. HUBER: With regard to the transfer of the pediatric clinic patients to other area providers,

the hospital has agreed to support the Community Health Center in New Britain with the hiring of either a pediatrician or a pediatric nurse practitioner. This individual would be dedicated to the transition and care of the hospital's current pediatric clinic patients.

Who determines what type of provider will be hired when CHC assumes, in part, the care of the hospital's current clinic patients?

MS. JANATKA: CHC will determine that.

MR. HUBER: They will determine?

MS. JANATKA: Yes.

MR. HUBER: And for what period of time will the hospital -- hospital funding be provided for that position?

MS. JANATKA: I believe we agreed to a year.

MR. HUBER: That concludes my questions.

MS. ROBERTS: I have one follow-up to that. I think it was said earlier that the current physician staffing the clinic is already notifying her patient base. I assume, in an effort, that they can continue to see her for continuation of having the same provider.

Was it assumed that most of the clinic

patients would be going to the Community Health Center, or would be going out to the community physicians, such as the one that's leaving the clinic now?

DR. GOLIOTO: So I think the assumption has been that most of the patients would go to the Community Health Center. This is a relatively recent development, that our current pediatrician will be joining a private practice in the New Britain community, so, certainly, we want to facilitate the patients to go to their choice of provider.

MS. ROBERTS: And in your notification that will be sent out, it will include all the options for access?

DR. GOLIOTO: That's correct.

MS. ROBERTS: Just for clarification, as it relates to that staff member that will be at the Community Health Center, but paid for by HOCC, in the financials, it looks like it was reflected that that person would be an HOCC employee. Is that correct?

MS. FREIHEIT: Carolyn Freiheit, Vice President of Finance. That was reflected as a change in the salary line just for presentation purposes. It was a net in the expense line.

MS. ROBERTS: Yeah, so, this is not going

to be a salary paid by HOCC?

MS. FREIHEIT: No.

MS. ROBERTS: It's a salary paid by CHC?

MS. FREIHEIT: That's correct. We will be reimbursing them.

MS. ROBERTS: Okay. I'm not sure we want to see the financial projection, so that it doesn't show up on the salary and fringe line.

MS. FREIHEIT: We can do that, if you'd like.

MS. ROBERTS: On contractual or one of the more appropriate lines. If we could have the financial projections then resubmitted, in light of that, as a late file?

HEARING OFFICER HANSTED: That will be Late File No. 3.

MS. FELDMAN: Ms. Roberts, since we're talking about the financial projections, are there any other adjustments that you would like to see in that, because you had an earlier question about the financials?

MS. ROBERTS: My question before was mostly to make sure that there wasn't going to be an estimated reduction in either ED visits or surgery related or indirectly related to this that could, then,

translate into the financial projections going forward, but it appears that there is no projected decrease in either one of those two areas, so it looks like the only thing that needs to change on the financials is the reflection of what will be a CHC staff member supported by HOCC.

MS. FELDMAN: Yeah, and, just to clarify, I think it's difficult for us to predict at this point what those reductions might be, so that's the reason why they had not been made.

HEARING OFFICER HANSTED: The reductions in the ED visits?

MS. FELDMAN: In ED visits.

MS. ROBERTS: That's all I have.

HEARING OFFICER HANSTED: Okay. I don't have any further questions. I think we've fleshed this out pretty thoroughly.

At this point, I just want to take a five-minute break, and we'll report back here at 25 after 6:00.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're back on the record. Karen, did you have another?

MS. ROBERTS: Yes. I think we need one

more minor late file. Just a full fiscal year number for outpatient pediatric clinic visits. In the CON, the number of 3,500 was annualized through June 2015. If we could have the final, or do you have it?

MS. NANCY KROEBER: I have it. Nancy Kroeber, Vice President of Operations. Our actual total pediatric clinic visits for fiscal year '15 was 3,600.

COURT REPORTER: Can you state and spell your name? I missed it. Sorry.

MS. KROEBER: Kroeber, K-R-O-E-B-E-R, Nancy.

COURT REPORTER: Thank you.

MS. ROBERTS: Thank you. That means we don't need it as a late file. Very good.

HEARING OFFICER HANSTED: Perfect.

(Whereupon, the hearing portion of the hearing concluded.)

HEARING RE: HOSPITAL OF CENTRAL CONNECTICUT
DECEMBER 2, 2015

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 7th day of December, 2015.

Paul Landman
President

Post Reporting Service
1-800-262-4102

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman, Esq.
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

December 16, 2015

VIA HAND DELIVERY

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: **IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS**
DOCKET NO: 15-32023-CON - LATE FILE

Dear Ms. Martone:

Enclosed please find the late file regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan Feldman

Joan W. Feldman

Jwf/tja
Enclosure
4431393v1

15-32023-C0N 12/16/2015 0149

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE HOSPITAL OF CENTRAL CONNECTICUT'S PROPOSAL TO TERMINATE ITS INPATIENT AND OUTPATIENT PEDIATRIC PROGRAMS	:	**DOCKET NO. 15-32023-CON**
	:	
	:	
	:	**December 16, 2015**

OHCA HEARING - EXHIBIT AND LATE FILE FORM

1. **Listing of Asthma Programs itemized by the following categories: Provided by, funded by and/or supported by the Hospital of Central Connecticut.**

The Hospital of Central Connecticut (the "Hospital") is an active participant in the statewide asthma initiative to improve patient care and access sponsored by the Connecticut Hospital Association ("CHA"). The CHA initiative will mobilize hospitals in collaboration with their community partners to identify barriers and challenges in the delivery system for children with asthma, develop population specific models of intervention and share best practices statewide to foster sustainability of results. The Hospital also participates in and supports the Pediatric Asthma Disease Management Program, an initiative developed by Hospital for Special Care to help patients with a diagnosis of asthma maintain a stable state of health and improve health outcomes. The Hospital collaborates and partners with the Hospital for Special Care by referring pediatric asthma cases to their specialized asthma programs. To the extent that pediatric asthma patients continue to present to the Hospital's emergency department, patients will continue to be referred by the emergency department to the Hospital for Special Care's program as indicated. Additionally, the Hospital supports the City of New Britain asthma education prevention program and serves on a collaborative with the Health Department and other community organizations, including the Community Health Center and New Britain Board of Education on the Coalition for New Britain Youth focused on health and wellness, including special emphasis on obesity and physical activity. In summary, the efforts for which the Hospital is collaboratively involved with will continue regardless of OHCA's decision.

2. A. Historical Financials for the Hospital's Inpatient Pediatric Service for FYs 2013 through 2015.

Please see Exhibit 1.

2. B. Historical Financials for the Hospital's Outpatient Pediatric Clinic Service for FYs 2013 through 2015.

Please See Exhibit 2.

3. Revised Financial Projections taking into consideration the changing revenue/expense considerations discussed during the public hearing. An explanation of the changes made in developing the revised financial projections should accompany the projections.

Please see Exhibit 3.

Note: This worksheet has been revised to reflect the reclassification of the salary and benefit expense of the CHC physician hire from salary and benefits to purchased services as requested by OHCA.

EXHIBIT 18

Prior 3 Year Analysis

Exhibit 1

LINE	Total Entity:	(1) FY13 Actual Results	(2) FY13 IP Pediatric Service	(3) FY13 Actual w /o IP Ped Service	(4) FY14 Actual Results	(5) FY14 IP Pediatric Service	(6) FY14 Actual w /o IP Ped Service	(7) FY15 Actual Results	(8) FY15 IP Pediatric Service	(9) FY15 Actual w /o IP Ped Service
	Description									
A.	**OPERATING REVENUE**									
1	Total Gross Patient Revenue	$894,561,269	($3,107,528)	$891,453,741	$864,609,377	($1,798,027)	$862,811,350	$862,643,114		$862,643,114
2	Less: Allowances	$496,600,768	($1,744,405)	$494,856,363	$480,182,282	($927,175)	$479,255,107	$508,692,046		$508,692,046
3	Less: Charity Care	$16,310,702		$16,310,702	$17,256,889		$17,256,889	$9,707,352		$9,707,352
4	Less: Other Deductions	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$381,649,799**	**($1,363,123)**	**$380,286,676**	**$367,170,206**	**($870,852)**	**$366,299,354**	**$344,243,716**	**$0**	**$344,243,716**
5	Medicare	$140,693,224		$140,693,224	$135,788,572		$135,788,572	$128,159,783		$128,159,783
6	Medicaid	$59,259,456	($1,109,515)	$58,149,941	$62,741,144	($658,170)	$62,082,974	$60,194,597		$60,194,597
7	CHAMPUS & TriCare	$375,866		$375,866	$153,445		$153,445	$225,017		$225,017
8	Other	$0		$0	$0		$0			$0
	Total Government	**$200,328,546**	**($1,109,515)**	**$199,219,031**	**$198,683,161**	**($658,170)**	**$198,024,991**	**$188,579,397**	**$0**	**$188,579,397**
9	Commercial Insurers	$2,331,868	($253,608)	$2,078,260	$2,897,804	($253,608)	$2,644,196	$2,963,704		$2,963,704
10	Uninsured			$0			$0	$0		$0
11	Self Pay	$1,278,286		$1,278,286	$670,153		$670,153	$1,535,251		$1,535,251
12	Workers Compensation	$6,249,591		$6,249,591	$7,659,362		$7,659,362	$7,205,096		$7,205,096
13	Other	$150,745,850		$150,745,850	$143,671,531		$143,671,531	$143,453,191		$143,453,191
	Total Non-Government	**$160,605,595**	**($253,608)**	**$160,351,987**	**$154,898,850**	**($253,608)**	**$154,645,242**	**$155,157,242**	**$0**	**$155,157,242**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$360,934,141**	**($1,363,123)**	**$359,571,018**	**$353,582,011**	**($911,778)**	**$352,670,233**	**$343,736,639**	**$0**	**$343,736,639**
14	Less: Provision for Bad Debts	$9,742,308		$9,742,308	$5,458,239		$5,458,239	$5,091,859		$5,091,859
	Net Patient Service Revenue less provision for bad debts	**$371,907,491**	**($1,363,123)**	**$370,544,368**	**$361,711,967**	**($870,852)**	**$360,841,115**	**$339,151,857**	**$0**	**$339,151,857**
15	Other Operating Revenue	$17,233,898		$17,233,898	$11,024,317		$11,024,317	$11,782,388		$11,782,388
17	Net Assets Released from Restrictions	$1,885,094		$1,885,094	$1,351,596		$1,351,596	$1,128,658		$1,128,658
	TOTAL OPERATING REVENUE	**$391,026,483**	**($1,363,123)**	**$389,663,360**	**$374,087,880**	**($870,852)**	**$373,217,028**	**$352,062,903**	**$0**	**$352,062,903**
B.	**OPERATING EXPENSES**									
1	Salaries and Wages	$168,706,840	($1,313,772)	$167,393,068	$148,416,218	($1,083,617)	$147,332,601	$142,646,540	($198,286)	$142,448,254
2	Fringe Benefits	$51,728,525	($394,132)	$51,334,393	$45,122,344	($325,085)	$44,797,259	$44,805,153	($59,486)	$44,745,667
3	Physicians Fees	$10,145,410		$10,145,410	$9,980,614		$9,980,614	$10,254,946		$10,254,946
4	Supplies and Drugs	$54,189,600	($56,350)	$54,133,250	$49,864,651	($30,420)	$49,834,231	$49,956,892		$49,956,892
5	Depreciation and Amortization	$19,479,333		$19,479,333	$18,225,335		$18,225,335	$19,494,513		$19,494,513
6	Provision for Bad Debts-Other[b]	$0		$0	$0		$0	$0		$0
7	Interest Expense	$1,563,598		$1,563,598	$1,418,199		$1,418,199	$1,836,605		$1,836,605
8	Malpractice Insurance Cost	$2,558,127		$2,558,127	$3,957,824		$3,957,824	$3,527,444		$3,527,444
9	Lease Expense	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$69,075,774		$69,075,774	$82,318,899		$82,318,899	$82,584,604		$82,584,604
	TOTAL OPERATING EXPENSES	**$377,447,207**	**($1,764,254)**	**$375,682,953**	**$359,304,084**	**($1,439,122)**	**$357,864,962**	**$355,106,697**	**($257,772)**	**$354,848,925**
	INCOME/(LOSS) FROM OPERATIONS	**$13,579,276**	**$401,131**	**$13,980,407**	**$14,783,796**	**$568,270**	**$15,352,066**	**($3,043,794)**	**$257,772**	**($2,786,022)**
	NON-OPERATING REVENUE	**$11,638,482**		**$11,638,482**	**$9,562,104**		**$9,562,104**	**($1,142,821)**		**($1,142,821)**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$25,217,758**	**$401,131**	**$25,618,889**	**$24,345,900**	**$568,270**	**$24,914,170**	**($4,186,615)**	**$257,772**	**($3,928,843)**
	Principal Payments	$2,165,699		$2,165,699	$2,329,243		$2,329,243	$872,430		$872,430
C.	**PROFITABILITY SUMMARY**									
1	Hospital Operating Margin	**3.4%**	**-29.4%**	**3.5%**	**3.9%**	**-65.3%**	**4.0%**	**-0.9%**	**0.0%**	**-0.8%**
2	Hospital Non Operating Margin	**2.9%**	**0.0%**	**2.9%**	**2.5%**	**0.0%**	**2.5%**	**-0.3%**	**0.0%**	**-0.3%**
3	Hospital Total Margin	**6.3%**	**-29.4%**	**6.4%**	**6.3%**	**-65.3%**	**6.5%**	**-1.2%**	**0.0%**	**-1.1%**
D.	**FTEs**	2,273	(11)	2,262	2,002	(6)	1,996	1,838	(1)	1,837
E.	**VOLUME STATISTICS[c]**									
1	Inpatient Discharges	17,907	(237)	17,670	15,640	(135)	15,505	15,230	0	15,230
	TOTAL VOLUME	**17,907**	**(237)**	**17,670**	**15,640**	**(135)**	**15,505**	**15,230**	**0**	**15,230**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT 19

Exhibit 2

Prior 3 Year Analysis

LINE	Total Entity:	(1) FY13 Actual	(2) FY13 OP Pediatric	(3) FY13 Actual w /o	(4) FY14 Actual	(5) FY14 OP Pediatric	(6) FY14 Actual w /o	(7) FY15 Actual	(8) FY15 OP Pediatric	(9) FY15 Actual w /o
	Description	Results	Service	OP Ped Service	Results	Service	OP Ped Service	Results	Service	OP Ped Service
A.	OPERATING REVENUE									
1	Total Gross Patient Revenue	$894,561,299	($1,301,279)	$893,259,990	$864,609,377	($1,190,848)	$863,412,529	$862,643,114	($800,999)	$861,836,215
2	Less: Allowances	$496,600,768	($864,287)	$495,716,481	$480,182,282	($817,995)	$479,364,287	$508,922,046	($544,136)	$508,147,908
3	Less: Charity Care	$16,310,702		$16,310,702	$17,256,899		$17,256,899	$9,707,352		$9,707,352
4	Less: Other Deductions	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	$381,649,799	($436,992)	$381,232,807	$367,170,296	($378,843)	$366,791,343	$344,243,716	($262,761)	$343,980,955
5	Medicare	$140,893,224	($163)	$140,893,061	$135,788,572	($253)	$135,788,309	$128,159,783	($176)	$128,159,606
6	Medicaid	$59,259,459	($411,558)	$58,847,899	$62,741,144	($373,245)	$62,367,899	$60,194,597	($259,411)	$59,935,186
7	CHAMPUS & TriCare	$375,866		$375,866	$153,445		$153,445	$225,017		$225,017
8	Other	$0		$0	$0		$0	$0		$0
	Total Government	$200,328,548	($411,721)	$199,916,826	$198,683,161	($373,598)	$198,309,653	$188,579,397	($259,588)	$188,319,808
9	Commercial Insurers	$2,331,665	($4,652)	$2,327,016	$2,997,804	($4,458)	$2,993,346	$2,993,704	($2,406)	$2,991,298
10	Uninsured	$0		$0	$0		$0	$0		$0
11	Self Pay	$1,278,286	($419)	$1,277,867	$670,153	($886)	$669,267	$1,535,251	($766)	$1,534,485
12	Workers Compensation	$6,249,591		$6,249,591	$7,859,362		$7,859,362	$7,205,096		$7,205,096
13	Other	$150,745,850		$150,745,850	$143,671,531		$143,671,531	$143,453,191		$143,453,191
	Total Non-Government	$160,605,665	($5,271)	$160,600,334	$154,898,850	($5,344)	$154,893,506	$155,187,242	($3,172)	$155,184,070
	Net Patient Service Revenue* (Government+Non-Government)	$360,934,141	($416,992)	$360,517,149	$353,582,011	($378,843)	$353,203,168	$343,766,638	($262,761)	$343,473,878
14	Less: Provision for Bad Debts	$9,742,308		$9,742,308	$5,458,230		$5,458,230	$5,061,859		$5,061,859
	Net Patient Service Revenue less provision for bad debts	$371,907,481	($416,992)	$371,490,489	$361,711,867	($378,843)	$361,333,114	$339,161,867	($262,761)	$338,899,996
15	Other Operating Revenue	$17,233,998		$17,233,998	$11,024,317		$11,024,317	$11,782,388		$11,782,388
17	Net Assets Released from Restrictions	$1,885,004		$1,885,004	$1,351,596		$1,351,596	$1,126,658		$1,126,658
	TOTAL OPERATING REVENUE	$391,026,483	($416,992)	$390,609,491	$374,087,880	($378,843)	$373,709,027	$352,062,993	($262,761)	$351,800,142
B.	OPERATING EXPENSES									
1	Salaries and Wages	$166,706,840	($437,852)	$166,268,988	$148,416,218	($397,975)	$148,018,243	$142,646,540	($249,288)	$142,397,252
2	Fringe Benefits	$51,728,525	($131,359)	$51,597,166	$45,122,344	($107,453)	$45,014,891	$44,805,153	($67,308)	$44,737,845
3	Physicians Fees	$10,145,410		$10,145,410	$9,980,614		$9,980,614	$10,254,946		$10,254,946
4	Supplies and Drugs	$54,189,600		$54,189,600	$49,864,651		$49,864,651	$49,958,992		$49,958,992
5	Depreciation and Amortization	$19,479,333		$19,479,333	$18,225,335		$18,225,335	$19,494,513		$19,494,513
6	Provision for Bad Debts-Other*	$0		$0	$0		$0	$0		$0
7	Interest Expense	$1,563,566		$1,563,566	$1,418,199		$1,418,199	$1,836,905		$1,836,905
8	Malpractice Insurance Cost	$2,558,127		$2,558,127	$3,957,824		$3,957,824	$3,527,444		$3,527,444
9	Lease Expense	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$99,075,774		$99,075,774	$92,316,899		$92,316,899	$82,564,604		$82,564,604
	TOTAL OPERATING EXPENSES	$377,447,207	($569,208)	$376,877,998	$349,304,084	($505,428)	$348,798,656	$355,196,697	($316,596)	$354,780,101
	INCOME/(LOSS) FROM OPERATIONS	$13,579,276	$152,216	$13,731,492	$14,783,796	$126,578	$14,910,371	($3,043,784)	$53,836	($2,989,968)
	NON-OPERATING REVENUE	$11,638,482		$11,638,482	$9,582,104		$9,582,104	($1,142,821)		($1,142,821)
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$25,217,758	$152,216	$25,369,974	$24,365,900	$126,578	$24,472,475	($4,186,616)	$53,836	($4,132,780)
	Principal Payments	$2,165,699		$2,165,699	$2,329,243		$2,329,243	$672,430		$672,430
C.	PROFITABILITY SUMMARY									
1	Hospital Operating Margin	3.4%	-36.8%	3.4%	3.8%	-33.4%	3.8%	-0.9%	-29.8%	-0.9%
2	Hospital Non Operating Margin	2.8%	0.0%	2.8%	2.6%	0.0%	2.6%	-0.3%	0.0%	-0.3%
3	Hospital Total Margin	6.3%	-36.8%	6.3%	6.3%	-33.4%	6.4%	-1.2%	-29.8%	-1.2%
D.	FTEs	2,273	(5)	2,268	2,002	(4)	1,998	1,836	(3)	1,833
E.	VOLUME STATISTICS*									
1	Outpatient Visits	285,016	(5,593)	279,423	266,733	(6,344)	260,389	262,536	(3,600)	258,936
	TOTAL VOLUME	285,016	(5,593)	279,423	266,733	(6,344)	260,389	262,536	(3,600)	258,936

*Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT 20

Exhibit 3

NON-PROFIT

Applicant:

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format.

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	864,609,377	838,089,000	($848,190)	$837,240,810	$813,777,000	($865,154)	$812,911,846	$806,441,000	($891,109)	$805,549,891	$804,788,000	($908,931)	$803,879,069
2	Less: Allowances	480,182,282	$494,373,000	($635,521)	$493,737,479	$463,574,818	($652,485)	$462,922,333	$455,018,235	($678,440)	$454,339,795	$449,691,006	($696,262)	$448,994,744
3	Less: Charity Care	17,256,889	$11,390,000		$11,390,000	$11,299,306		$11,299,306	$11,235,310		$11,235,310	$11,226,453		$11,226,453
4	Less: Other Deductions	0			$0			$0			$0			$0
	Net Patient Service Revenue	**367,170,206**	**$332,326,000**	**($212,669)**	**$332,113,331**	**$338,902,876**	**($212,669)**	**$338,690,207**	**$340,187,455**	**($212,669)**	**$339,974,786**	**$343,870,541**	**($212,669)**	**$343,657,872**
5	Medicare	138,054,052	$124,952,815		$124,952,815	$127,425,686		$127,425,686	$127,908,681		$127,908,681	$129,293,501		$129,293,501
6	Medicaid	59,639,703	$53,979,935	($212,669)	$53,767,266	$55,048,222	($212,669)	$54,835,553	$55,256,877	($212,669)	$55,044,208	$55,855,123	($212,669)	$55,642,454
7	CHAMPUS & TriCare	282,264	$255,477		$255,477	$260,533		$260,533	$261,521		$261,521	$264,352		$264,352
8	Other				$0			$0			$0			$0
	Total Government	**197,976,019**	**$179,188,228**	**($212,669)**	**$178,975,559**	**$182,734,441**	**($212,669)**	**$182,521,772**	**$183,427,078**	**($212,669)**	**$183,214,409**	**$185,412,976**	**($212,669)**	**$185,200,307**
9	Commercial Insurers	150,846,850	$136,531,585		$136,531,585	$139,233,604.65		$139,233,605	139,761,356		$139,761,356	141,274,502		$141,274,502
10	Uninsured				$0			$0			$0			$0
11	Self Pay	8,818,166	$7,981,328		$7,981,328	$8,139,281.92		$8,139,282	8,170,133		$8,170,133	8,258,588		$8,258,588
12	Workers Compensation	5,499,389	$4,977,501		$4,977,501	$5,076,007.58		$5,076,008	5,095,248		$5,095,248	5,150,412		$5,150,412
13	Other	4,029,782	$3,647,358		$3,647,358	$3,719,541.20		$3,719,541			$0			$0
	Total Non-Government	**169,194,187**	**$153,137,772**	**$0**	**$153,137,772**	**$156,168,435**	**$0**	**$156,168,435**	**$153,026,737**	**$0**	**$153,026,737**	**$154,683,502**	**$0**	**$154,683,502**
	Net Patient Service Revenue[a] (Government+Non-Government)	**367,170,206**	**$332,326,000**	**($212,669)**	**$332,113,331**	**$338,902,876**	**($212,669)**	**$338,690,207**	**$336,453,815**	**($212,669)**	**$336,241,146**	**$340,096,478**	**($212,669)**	**$339,883,809**
14	Less: Provision for Bad Debts	5,458,239	$6,175,000		$6,175,000	$6,126,847		$6,126,847	$6,092,146		$6,092,146	$6,087,343		$6,087,343
	Net Patient Service Revenue less provision for bad debts	**361,711,967**	**$326,151,000**	**($212,669)**	**$325,938,331**	**$332,776,029**	**($212,669)**	**$332,563,360**	**$334,095,309**	**($212,669)**	**$333,882,640**	**$337,783,198**	**($212,669)**	**$337,570,529**
15	Other Operating Revenue	11,024,317	$15,152,000		$15,152,000	$15,912,000		$15,912,000	$16,289,000		$16,289,000	$16,676,000		$16,676,000
17	Net Assets Released from Restrictions	1,351,596	$1,400,000		$1,400,000	$1,416,000		$1,416,000	$1,465,000		$1,465,000	$1,517,000		$1,517,000
	TOTAL OPERATING REVENUE	**374,087,880**	**$342,703,000**	**($212,669)**	**$342,490,331**	**$350,104,029**	**($212,669)**	**$349,891,360**	**$351,849,309**	**($212,669)**	**$351,636,640**	**$355,976,198**	**($212,669)**	**$355,763,529**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	148,416,218	$138,379,000	($881,601)	$137,497,399	$141,541,000	($903,641)	$140,637,359	$145,221,000	($908,049)	$144,312,951	$150,014,000	($926,210)	$149,087,790
2	Fringe Benefits	45,122,344	$41,719,000	($202,000)	$41,517,000	$42,387,000	($202,000)	$42,185,000	$43,526,000	($202,000)	$43,324,000	$44,986,000	($202,000)	$44,784,000
3	Physicians Fees	9,980,614	$10,180,000	$220,000	$10,400,000	$10,000,000		$10,000,000	$10,025,000		$10,025,000	$10,056,000		$10,056,000
4	Supplies and Drugs	49,864,651	$35,915,000		$35,915,000	$39,331,000		$39,331,000	$39,669,000		$39,669,000	$41,526,000		$41,526,000
5	Depreciation and Amortization	18,225,335	$19,460,000		$19,460,000	$14,085,000		$14,085,000	$12,103,000		$12,103,000	$10,641,000		$10,641,000
6	Provision for Bad Debts-Other[b]	0	$0		$0			$0			$0			$0
7	Interest Expense	1,418,199	$3,268,000		$3,268,000	$3,221,000		$3,221,000	$3,219,000		$3,219,000	$3,087,000		$3,087,000
8	Malpractice Insurance Cost	3,957,824	$3,635,000		$3,635,000	$3,748,000		$3,748,000	$3,860,000		$3,860,000	$3,168,000		$3,168,000
9	Lease Expense		$0		$0			$0			$0			$0
10	Other Operating Expenses	82,318,899	$81,400,000		$81,400,000	$83,005,000		$83,005,000	$80,487,000		$80,487,000	$78,616,000		$78,616,000
	TOTAL OPERATING EXPENSES	**359,304,084**	**$333,956,000**	**($863,601)**	**$333,092,399**	**$337,318,000**	**($1,105,641)**	**$336,212,359**	**$338,110,000**	**($1,110,049)**	**$336,999,951**	**$342,094,000**	**($1,128,210)**	**$340,965,790**
	INCOME/(LOSS) FROM OPERATIONS	**14,783,796**	**$8,747,000**	**$650,932**	**$9,397,932**	**$12,786,029**	**$892,972**	**$13,679,001**	**$13,739,309**	**$897,380**	**$14,636,689**	**$13,882,198**	**$915,541**	**$14,797,739**
	NON-OPERATING REVENUE	**9,562,104**	**$2,000,000**		**$2,000,000**	**$5,000,000**		**$5,000,000**	**$5,000,000**		**$5,000,000**	**$5,000,000**		**$5,000,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**24,345,900**	**$10,747,000**	**$650,932**	**$11,397,932**	**$17,786,029**	**$892,972**	**$18,679,001**	**$18,739,309**	**$897,380**	**$19,636,689**	**$18,882,198**	**$915,541**	**$19,797,739**
	Principal Payments	2,329,000	$2,100,000		$2,100,000	$1,950,000		$1,950,000	$1,800,000		$1,800,000	$1,700,000		$1,700,000
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	3.85%	2.5%	-306.1%	2.7%	3.6%	-419.9%	3.9%	3.9%	-422.0%	4.1%	3.8%	-430.5%	4.1%
2	Hospital Non Operating Margin	2.49%	0.6%	0.0%	0.6%	1.4%	0.0%	1.4%	1.4%	0.0%	1.4%	1.4%	0.0%	1.4%
3	Hospital Total Margin	6.35%	3.1%	-306.1%	3.3%	5.0%	-419.9%	5.3%	5.3%	-422.0%	5.5%	5.2%	-430.5%	5.5%
D.	**FTEs**	1,894	1,788	(6)	1,782	1,788	(6)	1,782	1,788	(6)	1,782	1,788	(6)	1,782
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	15,640	14,750		14,750	14,750		14,750	14,750		14,750	14,750		14,750
2	Outpatient Visits	403,498	411,568	(3,500)	408,068	415,684	(3,500)	412,184	417,762	(3,500)	414,262	418,806	(3,500)	415,306
	TOTAL VOLUME	**419,138**	**426,318**	**(3,500)**	**422,818**	**430,434**	**(3,500)**	**426,934**	**432,512**	**(3,500)**	**429,012**	**433,556**	**(3,500)**	**430,056**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Foster, Tillman
Sent: Wednesday, December 23, 2015 4:27 PM
To: Greer, Leslie
Subject: FW: Late File Follow-up DN: 15-32023

From: Foster, Tillman
Sent: Wednesday, December 23, 2015 12:35 PM
To: Barbara Durdy (HHC) <Barbara.Durdy@hhchealth.org>
Cc: Feldman, Joan <JFeldman@goodwin.com>; Huber, Jack <Jack.Huber@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Late File Follow-up DN: 15-32023

Barbara-

As a follow-up to your December 16, 2015 late file submission, please verify as indicated in the tables below that there will be no projected revenue or expenses that will be generated by the dedicated pediatric inpatient unit and the outpatient pediatric clinic - the two service lines earmarked for termination in the proposal.

PROJECTED INCREMENTAL REVENUES AND EXPENSES
FISCAL YEARS 2016-2018

Inpatient Pediatric Unit	**FY 2017**	**FY 2018**	**FY 2019**
Revenue from Operations	($0)	($0)	($0)
Total Operating Expenses	($0)	($0)	($0)
Gain/(Loss) from Operations	$0	$0	$0

Outpatient Pediatric Clinic	**FY 2017**	**FY 2018**	**FY 2019**
Revenue from Operations	($0)	($0)	($0)
Total Operating Expenses	($0)	($0)	($0)
Gain/(Loss) from Operations	$0	$0	$0

A simple response can be provided in email fashion to me and Jack Huber.

Thank you for addressing this matter.

Best wishes and enjoy your holidays.

Tillman

Tillman Foster
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access

410 Capitol Avenue
MS #13HCA, P.O. Box 340308
Hartford, CT 06134
Phone: (860) 418-7031
Fax: (860) 418-7053
Email: Tillman.Foster@CT.GOV

Greer, Leslie

From: Foster, Tillman
Sent: Tuesday, December 29, 2015 12:52 PM
To: Greer, Leslie
Subject: FW: Late File Follow-up DN: 15-32023

From: Durdy, Barbara [mailto:Barbara.Durdy@hhchealth.org]
Sent: Tuesday, December 29, 2015 12:47 PM
To: Foster, Tillman <Tillman.Foster@ct.gov>
Cc: Feldman, Joan <JFeldman@goodwin.com>; Huber, Jack <Jack.Huber@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Goyette, Karen T. <Karen.Goyette@hhchealth.org>; Freiheit, Carolyn <Carolyn.Freiheit@hhchealth.org>; Kroeber, Nancy <Nancy.Kroeber@hhchealth.org>
Subject: RE: Late File Follow-up DN: 15-32023

Tillman,
As we just discussed by telephone, there will be no incremental expenses or revenues from the pediatric inpatient service or outpatient clinic once the services are terminated.
Thank you for taking the time to speak with me,
Barbara

Barbara A. Durdy
Director, Strategic Planning

Hartford HealthCare

181 Patricia M. Genova Blvd.

Newington, CT 06111

Office: 860.972.4231

Cell: 203.859.8174

barbara.durdy@hhchealth.org

www.hartfordhealthcare.org

From: Foster, Tillman [mailto:Tillman.Foster@ct.gov]
Sent: Wednesday, December 23, 2015 12:35 PM
To: Durdy, Barbara
Cc: Feldman, Joan; Huber, Jack; Roberts, Karen
Subject: Late File Follow-up DN: 15-32023

Barbara-

As a follow-up to your December 16, 2015 late file submission, please verify as indicated in the tables below that there will be no projected revenue or expenses that will be generated by the dedicated pediatric inpatient unit and the outpatient pediatric clinic - the two service lines earmarked for termination in the proposal.

PROJECTED INCREMENTAL REVENUES AND EXPENSES
FISCAL YEARS 2016-2018

Inpatient Pediatric Unit	**FY 2017**	**FY 2018**	**FY 2019**
Revenue from Operations	($0)	($0)	($0)
Total Operating Expenses	($0)	($0)	($0)
Gain/(Loss) from Operations	$0	$0	$0

Outpatient Pediatric Clinic	**FY 2017**	**FY 2018**	**FY 2019**
Revenue from Operations	($0)	($0)	($0)
Total Operating Expenses	($0)	($0)	($0)
Gain/(Loss) from Operations	$0	$0	$0

A simple response can be provided in email fashion to me and Jack Huber.

Thank you for addressing this matter.

Best wishes and enjoy your holidays.

Tillman

Tillman Foster
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA, P.O. Box 340308
Hartford, CT 06134
Phone: (860) 418-7031
Fax: (860) 418-7053
Email: Tillman.Foster@CT.GOV

Greer, Leslie

From: Foster, Tillman
Sent: Wednesday, December 30, 2015 1:22 PM
To: Feldman, Joan
Cc: Barbara Durdy (HHC); Lazarus, Steven; Hansted, Kevin; Riggott, Kaila; Roberts, Karen; Veyberman, Alla; Greer, Leslie
Subject: 15-32023-CON Close Hearing Ltr
Attachments: 32023 Close of Hearing Ltr..pdf

Joan-

Please see the attached Closure of Hearing letter.

Please let me know if you have any questions regarding the attached notice.

Thank you,

Tillman

Tillman Foster
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA, P.O. Box 340308
Hartford, CT 06134
Phone: (860) 418-7031
Fax: (860) 418-7053
Email: Tillman.Foster@CT.GOV

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 29, 2015

VIA EMAIL ONLY

Joan Feldman, Esq.
Shipman & Goodwin, LLP
c/o Hospital of Central Connecticut
One Constitution Plaza
Hartford, CT 06103-1919

RE: Certificate of Need Application, Docket Number 15-32023-CON
Hospital of Central Connecticut
Termination of Inpatient Pediatric Unit and Outpatient Pediatric Clinic Services
Closure of Public Hearing

Dear Attorney Feldman:

Please be advised, by way of this letter, the public hearing held on December 2, 2015, in the above referenced matter is hereby closed as of December 29, 2015. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Jack Huber at (860) 418-7069 or Tillman Foster at (860) 418-7031.

Sincerely,

Kevin T. Hansted
Hearing Officer

KTH:jh,tf

cc: Barbara Durdy, Hartford Health Care, Director Strategic Planning

Greer, Leslie

From: Feldman, Joan <JFeldman@goodwin.com>
Sent: Wednesday, December 30, 2015 2:59 PM
To: Foster, Tillman
Cc: Barbara Durdy (HHC); Lazarus, Steven; Hansted, Kevin; Riggott, Kaila; Roberts, Karen; Veyberman, Alla; Greer, Leslie
Subject: RE: 15-32023-CON Close Hearing Ltr

Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

From: Foster, Tillman [mailto:Tillman.Foster@ct.gov]
Sent: Wednesday, December 30, 2015 1:22 PM
To: Feldman, Joan
Cc: Barbara Durdy (HHC); Lazarus, Steven; Hansted, Kevin; Riggott, Kaila; Roberts, Karen; Veyberman, Alla; Greer, Leslie
Subject: 15-32023-CON Close Hearing Ltr

Joan-

Please see the attached Closure of Hearing letter.

Please let me know if you have any questions regarding the attached notice.

Thank you,

Tillman

Tillman Foster
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA, P.O. Box 340308
Hartford, CT 06134
Phone: (860) 418-7031
Fax: (860) 418-7053
Email: Tillman.Foster@CT.GOV

Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, February 10, 2016 5:27 PM
To: Barbara Durdy
Cc: 'Karen.Roberts@po.state.ct.us'; Huber, Jack; Foster, Tillman; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: The Hospital of Central CT Final Decision
Attachments: 32023 Final Decision.pdf

Tracking:

Recipient	Delivery	Read
Barbara Durdy		
'Karen.Roberts@po.state.ct.us'	Delivered: 2/10/2016 5:28 PM	
Huber, Jack	Delivered: 2/10/2016 5:28 PM	
Foster, Tillman	Delivered: 2/10/2016 5:28 PM	Read: 2/10/2016 5:35 PM
Riggott, Kaila	Delivered: 2/10/2016 5:28 PM	Read: 2/11/2016 7:47 AM
Hansted, Kevin	Delivered: 2/10/2016 5:28 PM	
Martone, Kim	Delivered: 2/10/2016 5:28 PM	
Roberts, Karen		Read: 2/11/2016 7:17 AM

Ms. Durdy,
Attached is the final decision for The Hospital of Central Connecticut.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Final Decision

Applicant: **The Hospital of Central Connecticut**
100 Grand Street, New Britain, CT 06050

Docket Number: **15-32023-CON**

Project Title: **Termination of Pediatric Inpatient Medical and Outpatient Clinic Services at The Hospital of Central Connecticut**

Project Description: The Hospital of Central Connecticut ("Hospital" or "Applicant") seeks authorization to terminate its pediatric inpatient medical and outpatient clinic services at the Hospital's campus in New Britain, Connecticut at no capital expenditure.

Procedural History: The Hospital published notice of its intent to file a Certificate of Need ("CON") application in the *New Britain Herald* (New Britain) on May 26, May 27 and May 28, 2015. On August 28, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Hospital for the above-referenced project. OHCA deemed the application complete on October 23, 2015.

On November 9, 2015, the Hospital was notified of the date, time, and place of the public hearing. On November 11, 2015, a notice to the public announcing the hearing was published in the *New Britain Herald.* Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e), a public hearing regarding the CON application was held on December 2, 2015.

Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(e). The public hearing record was closed on December 29, 2015. Deputy Commissioner Brancifort considered the entire record in this matter.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Findings of Fact and Conclusions of Law

1. The Hospital of Central Connecticut ("Hospital" or "Applicant") is a 446-bed (including bassinets) non-profit, acute care general hospital with its main campus located at 100 Grand Street in New Britain, Connecticut and its Bradley Memorial satellite campus located at 81 Meriden Avenue in Southington, Connecticut. Ex. A, pp. 44, 94

2. The Hospital proposes to terminate its pediatric inpatient medical and outpatient clinic services located at its New Britain campus and transition these services to other institutional and community-based providers. There are no pediatric services at the Hospital's Southington campus. The Hospital seeks this termination due to sustained declines in the demand for these services. Ex. A, pp. 11-12

3. Table 1 illustrates that the Hospital's existing inpatient pediatric service primarily serves the towns of New Britain and Southington and the pediatric outpatient clinic primarily serves the town of New Britain based on Fiscal Year ("FY") 2014 utilization figures.

TABLE 1
EXISTING HOSPITAL PEDIATRIC SERVICES

Existing Services	Service Area Towns and Percentage Utilization for FY 2014
Inpatient Pediatric Discharges	New Britain 68% Southington 9%
Outpatient Pediatric Clinic Visits	New Britain 86%

Ex. C, pp. 129 - 130

4. The Hospital provides pediatric inpatient medical services to patients, ages 6 months to 17 years. These services will be transitioned to Connecticut Children's Medical Center ("CCMC") in Hartford. The Hospital has maintained a patient transfer agreement specifically for its pediatric patients with CCMC for several years and, as a result of the continuing drop in the utilization of the inpatient pediatric services, the Hospital updated its Emergency Patient Transfer Agreement with CCMC in 2015 in an effort to ensure that there will be no interruption in care or services resulting from the proposed service termination of the inpatient services. Ex. A, pp. 12, 14, 18, 22, 71-76; Testimony of Ms. Lucille Janatka, President & Chief Executive Officer at The Hospital of Central Connecticut, p. 21

5. Due to clinical advances in treating vaccine-preventable illnesses, as well as advances in care for conditions such as asthma, diabetes and prematurity, care has significantly shifted toward the outpatient setting and the majority of children requiring inpatient care are now the most complicated cases often requiring subspecialty care, such as pediatric cardiologists and pulmonologists and testing modalities outside the scope of a community-based hospital program. With the transfer of care to CCMC, pediatric patients from the New Britain area will benefit from the full array of specialty, subspecialty and ancillary pediatric services

which CCMC provides as a dedicated Children's Hospital. Ex. A, pp. 12, 17, 87; Testimony of Annmarie Golioto, M.D., Chief of Pediatrics and Neonatologist of The Hospital of Central Connecticut, pp. 6-8

6. In the event that a pediatric patient could not be accommodated at CCMC, the Hospital is not precluded from contacting other hospitals that accept pediatric inpatients and making arrangements with that hospital for patient transfer. Testimony of David Bono, M.D., Chief of Emergency Medicine at The Hospital of Central Connecticut, p. 24

7. For FYs 2010 through 2014, the Hospital experienced difficulties in maintaining an average daily census above three patients in its pediatric inpatient unit. Ex. A, p. 13

8. The Hospital realized a steady decline in pediatric admissions beginning in FY 2014 as illustrated in Table 2. During 2014, the Hospital eliminated its two hospitalist positions due to an insufficient number of admissions to sustain this staffing. Since September 2014, there have been no pediatric medical admissions to the inpatient unit by area community referring physicians.

TABLE 2
HISTORICAL INPATIENT PEDIATRIC DISCHARGES

Inpatient Service	Historical Discharges					
	FY 2012	FY 2013	FY 2014	% Change FYs 13-14	FY 2015	% Change FYs 14-15
Discharges	191	237	135	(43.0%)*	0	(100.0%)*

Note: * Percentage values that are bracketed ("x%") denote a negative percentage.
Ex. A, pp. 13, 27; Testimony of Dr. Annmarie Golioto, p.15

9. The Hospital will continue to provide emergency medical services to pediatric patients in the Emergency Department ("ED"). If the ED physician or primary care physician deems inpatient care to be necessary which is outside the scope of the Hospital, then the patient will be transferred to CCMC. Ex. A, pp. 11, 92

10. Non-newborn pediatric medical patients who require inpatient admission are transferred to CCMC via ambulance from the HOCC ED. Ex. A., p. 17

11. The number of Hospital pediatric patients transferred to CCMC increased by 60% from 199 patients (including NICU patients) in FY 2014 to 319 patients in FY 2015 with the elimination of the pediatric hospitalist program and the changing referral patterns of the community-based pediatricians. Table 3 shows this breakout by service origination.

TABLE 3
HOSPITAL PEDIATRIC PATIENTS TRANSFERRED TO CCMC

Fiscal Year	Pediatric Patients Transferred From the Hospital's			
	ED	NICU	Inpatient Unit	Total Patients Transferred
FY 2014	185	8	6	199
FY 2015	311	8	0	319

Notes: NICU means neonatal intensive care unit.
Ex. C, p. 124; Testimony of Dr. Annmarie Golioto, M.D., p. 15

12. There will be no interruption in the provision of either routine or critical care services to Hospital newborns. Ex. A, pp. 11, 14, 78

13. The Hospital operates its pediatric clinic for children needing primary and preventative care visits as well as vision and hearing screenings and vaccinations. The Hospital provides outpatient pediatric clinic services at its New Britain campus on a Monday through Friday, 8:00 a.m. to 5:00 p.m. basis, with no extended, night or weekend hours or coverage available. The clinic does not provide behavioral health or dental care. Ex. A, p. 14, Ex. C, p. 132

14. The pediatric clinic primarily serves Medicaid patients. Only a small percentage of patients have commercial insurance (0.6%) or are uninsured (2.0%). Ex. C, p. 125

15. The Hospital developed a "Pediatric Clinic Transition of Care Plan" to facilitate the transition of care from its pediatric clinic service to Community Health Center of New Britain ("CHC-NB"), a federally-qualified health center located in New Britain, or to community-based practitioners and to ensure that there will be no interruption in care or services resulting from the closing of the clinic. Ex. A, pp. 14, 18, 23, 91

16. With the declining number of outpatient pediatric clinic visits annually and the retirement of one of the clinic's pediatricians, the Hospital reduced the number of pediatricians covering the clinic from two to one physician in August 2014. Ex. A, p. 14; Prefiled Testimony of Dr. Annmarie Golioto, M.D., p.144

17. Table 4 shows the pediatric clinic's historical volumes for FY 2012 through 2015 and the percentage change between years. The table demonstrates that, while there was an increase in visits from FY 2012 – 2013, the number of visits have decreased at an increasing rate from FY 2013 – FY 2015.

TABLE 4
HISTORICAL OUTPATIENT PEDIATRIC CLINIC VISITS

Outpatient Service	Historical Visits						
	FY 2012	FY 2013	% Change FYs 12-13	FY 2014	% Change FYs 13-14	FY 2015	% Change FYs 14-15
Clinic Visits	5,070	5,593	10.3%	5,344	(4.5%)*	3,600	(32.6%)*

Note: * Percentage values that are bracketed (x%) denote a negative percentage.

Ex. A, p. 27, Testimony of Joan Feldman, Esq., with Shipman & Goodwin, LLP, on behalf of The Hospital of Central Connecticut, p. 14; Testimony of Ms. Nancy Kroeber, Vice President of Operations at The Hospital of Central Connecticut, p.56

18. Outpatient pediatric services will be transitioned to CHC-NB and to local community based practitioners in New Britain and Southington, as well as the towns of Plainville, Bristol and Berlin. Table 5 lists the names and addresses of these existing local resources, as well as associated days and hours of operation:

TABLE 5
PEDIATRIC COMMUNITY PROVIDER SERVICES AND SERVICE LOCATIONS

Service	Provider Name and Address	Days and Hours of Operation
Licensed Outpatient Clinic	Community Health Center* of New Britain 85 Lafayette Street New Britain, CT 06051	Monday - Thursday: 8:00 AM - 6:30 PM Friday: 8:00 AM - 5:00 PM Saturday: 8:00 AM - 4:00 PM
Community Pediatricians	Grove Hill Medical Center 300 Kensington Avenue New Britain, CT 06051	Monday - Friday: 8:30 AM - 5:00 PM Weekend by appointment
	New Britain Pediatric Group 1095 West Main Street New Britain, CT 06053	Monday - Friday: 9:00 AM - 4:30 PM
	Phillips Foster, MD 40 Hart Street New Britain, CT 06051	Monday, Tuesday, Thursday: 9:00 AM - 3:00 PM
	Personal Care Pediatrics 340 North Main Street Southington, CT 06489	Monday - Thursday: 9:00 AM - 5:00 PM Friday: 9:00 AM - 3:00 PM
	Mark Peterson, MD 143 North Main Street Southington, CT 06489	Monday – Friday: 9:00 AM - 5:00 PM
	George Skarvinko, M.D. Southington Pediatric Associates 209 Main Street Southington, CT 06489	Monday – Friday: 8:00 AM – 5:00 PM
	Alpa Patel, MD 710 Main Street Southington, CT 06479	Monday – Wednesday: 8:00 AM - 5:00 PM Thursday: 8:00 AM – 12:00 P.M. Friday: 8:00 AM - 3:00 PM
	Multiple Providers at 184 East Street Plainville, CT 06062	Monday - Friday: 9:00 AM - 4:30 PM Weekend by appointment
	Teresa M. Szajda, M.D. 7 North Washington Street Plainville, CT 06062	Monday, Tuesday, Thursday and Friday: 8:00 AM – 5:00 PM
	Pediatric Care Center 780 Farmington Avenue Bristol, CT 06010	Monday, Wednesday, Thursday and Friday: 8:30 AM – 5:00 PM Tuesday: 8:30 AM - 7:00 PM
	Berlin Pediatric Associates 742 Worthington Road Berlin, CT 06037	Monday – Friday: 7:00 AM - 4:00 PM Saturday: 8:00 AM - 11:00 AM

*The Community Health Center of Bristol is also available to serve the patients in this area but the Applicant did not provide the days/hours of operation.

Ex. A pp. 11, 12, 18; Ex. C, pp. 126, 134-135; Prefiled Testimony of Dr. Annmarie Golioto, M.D., p. 145

19. CHC-NB offers a wide range of services including medical care, behavioral health, school-based and dentistry services and is able to offer expanded hours of operation to meet the needs of its patients. Pediatric clinic patients will have a choice of transitioning their care to CHC-NB or to a local pediatric provider such as those identified in Table 5. The Hospital has agreed to fund the salary and benefit expenses of a pediatrician or pediatric nurse practitioner at CHC-NB for a period of one year. Ex. A, pp. 14- 15, 80-86, 88-89; Ex. C, p. 131, Prefiled Testimony of Dr. Annmarie Golioto, M.D., p.145

20. CCMC and CHC-NB, as well as other community-based pediatric practitioners are prepared to accept the pediatric patients that have previously utilized the Hospital's inpatient unit and outpatient pediatric clinic. Ex, A, pp. 80-88; Ex. C. p. 126

21. There is no capital expenditure associated with the Hospital's proposal to terminate its pediatric services. Ex. A, pp. 20, 26

22. The Hospital projects overall gains in operations in each of the first three full fiscal years, FY 2016 through FY 2018, following the proposed service terminations.

TABLE 6
HOSPITAL'S PROJECTED REVENUES AND EXPENSES
FISCAL YEARS 2016-2018

Description	FY 2016	FY 2017	FY 2018
Revenue from Operations	$342,490,331	$349,891,360	$351,636,640
Total Operating Expenses	$333,092,399	$336,212,359	$336,999,951
Gain/(Loss) from Operations	$9,397,932	$13,679,001	$14,636,689

Late File 3, Revised financial projections for the proposal.

23. Table 7 illustrates that the Hospital's inpatient pediatric service has continued to experience revenue decreases over the last three fiscal years, 2013 through 2015.

TABLE 7
HOSPITAL'S ACTUAL REVENUES AND EXPENSES
INPATIENT PEDIATRIC SERVICE
FISCAL YEARS 2013-2015*

Description	FY 2013	FY 2014	FY 2015
Revenue from Operations	$1,363,123	$870,852	$0
Total Operating Expenses	$1,764,254	$1,439,122	$257,772
Gain/(Loss) from Operations	($401,131)	($568,270)	($257,772)

Late File 2.a. Revised inpatient pediatric financial projections.

24. Table 8 illustrates that the Hospital's outpatient pediatric clinic has also continued to experience revenue decreases over the last three fiscal years, 2013 through 2015.

TABLE 8
HOSPITAL'S ACTUAL REVENUES AND EXPENSES
OUTPATIENT PEDIATRIC SERVICE
FISCAL YEARS 2013-2015*

Description	FY 2013	FY 2014	FY 2015
Revenue from Operations	$416,992	$378,853	$262,761
Total Operating Expenses	$569,208	$505,428	$316,596
Gain/(Loss) from Operations	($152,216)	($126,575)	($53,835)

Late File 2.b. Revised outpatient pediatric financial projections.

25. The Hospital's actual inpatient pediatric payer mix for FY 2014 is as follows:

TABLE 9
HOSPITAL'S INPATIENT PEDIATRIC PAYER MIX
FISCAL YEAR 2014

Payer	FY 2014	
	Discharges	%*
Medicare**	0	0%
Medicaid**	90	67.67%
CHAMPUS & TriCare	1	0.75%
Total Government	**91**	**68.42%**
Commercial Insurers	39	29.32%
Uninsured	3	2.26%
Workers Compensation	0	0%
Total Non-Government	**42**	**31.58%**
Total Payer Mix	**133**	**100.00%**

Notes: * Numbers and percentages may reflect rounding
**Includes managed care activity
Ex. C, p. 128

26. This proposal will not negatively impact care for Medicaid recipients and indigent persons. CCMC and CHC-NB provide services for any patient in the region, regardless of their ability to pay. Many community-based pediatricians in the greater New Britain area accept Medicaid patients and are willing to accept Medicaid pediatric patients from the Hospital. Ex. A. p. 17; Ex. C, pp. 125-126

27. The Hospital's FY 2015 Community Health Needs Assessment identified child asthma (Ages 0-17) as an area for an opportunity for improvement in the hospital's service area. The Hospital continues to participate in and support effort related to pediatric asthma care as follows OHCA Exhibit #1, p. 27; Late File 1, p. 1

a. The Hospital participates in and supports the Pediatric Asthma Disease Management Program an initiative developed by Hospital for Special Care to help patients with a diagnosis of asthma maintain a stable state of health and improve health outcomes.

b. The Hospital collaborates and partners with the Hospital for Special Care by referring pediatric asthma cases to their specialized programs.

c. Pediatric Asthma patients presenting to the Hospital's emergency department will continue to be referred to the Hospital for Special Care's program.

d. The Hospital supports the City of New Britain asthma education prevention program.

28. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))
29. The CON application is consistent with the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

30. The Hospital has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

31. The Hospital has satisfactorily demonstrated that its proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

32. The Hospital has satisfactorily demonstrated that access to services, cost effectiveness and the quality of health care delivery will be maintained. (Conn. Gen. Stat. § 19a-639(a)(5))

33. The Hospital has shown that there will be no adverse change in the provision of health care services to the relevant populations and payer mix, including Medicaid patients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))

34. The Hospital has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

35. The Hospital has sufficiently demonstrated that there are other providers in the area being utilized by and available to the public and that these providers can continue to be utilized by the public. (Conn. Gen. Stat. § 19a-639(a)(8))

36. The Hospital has satisfactorily demonstrated that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

37. The Hospital has satisfactorily demonstrated that access to services for Medicaid recipients and indigent persons will be maintained. (Conn. Gen. Stat. § 19a-639(a)(10))

38. The Hospital has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. (Conn. Gen. Stat. § 19a-639(a)(11))

39. The Hospital has satisfactorily demonstrated that its proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in Conn. Gen. Stat. § 19a-639(a). The Hospital bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

The Hospital of Central Connecticut ("Hospital") is a non-profit, acute care general hospital with its main campus located at 100 Grand Street in New Britain and its satellite campus located at 81 Meriden Avenue in Southington. *FF1* The Hospital provides inpatient pediatric services at its New Britain campus. The inpatient pediatric services have historically served individuals primarily residing in the towns of New Britain and Southington. *FF3* Additionally, the Hospital provides outpatient pediatric clinic services at its New Britain campus on a Monday through Friday, 8:00 a.m. to 5:00 p.m. basis, with no extended, night or weekend hours or coverage available. *FF13* The outpatient pediatric clinic has historically served individuals residing primarily in the town of New Britain. *FF3*

The Hospital proposes to terminate its pediatric inpatient medical services and outpatient clinic services and transition these services to other institutional and community-based providers. The Hospital seeks to terminate these pediatric services due to a sustained decline in demand for such services. *FF2*

The Hospital's inpatient pediatric medical services will be transitioned to the Connecticut Children's Medical Center ("CCMC") in Hartford. *FF4* With the transfer of care to CCMC, pediatric patients from the New Britain area will benefit from the full array of specialty, subspecialty and ancillary pediatric services which CCMC provides as a dedicated Children's Hospital. *FF5* Outpatient pediatric clinic services will be transitioned to local providers, including the Community Health Center, Inc. a federally-qualified health center located in New Britain ("CHC-NB"), and several community-based private practitioners. *FF18* CCMC and CHC-NB, as well as other community-based pediatric practitioners are prepared to accept the pediatric patients that have previously utilized the Hospital's inpatient unit and outpatient pediatric clinic. *FF20*

The Hospital developed a "Pediatric Clinic Transition of Care Plan" to facilitate the transition of care from its pediatric clinic service to CHC-NB or community-based practitioners and to ensure that there will be no interruption in care or services resulting from the closing of the clinic. *FF15* CHC-NB offers a wide range of services including medical care, behavioral health, school-based and dentistry services and is able to offer expanded hours of operation to meet the needs of its patients. Pediatric clinic patients will have a choice of transitioning their care to CHC-NB or to a local pediatric provider. The Hospital has agreed to fund the salary and benefit expenses of a pediatrician or pediatric nurse practitioner at CHC-NB. *FF19*

There is no capital expenditure associated with termination of pediatric inpatient and pediatric outpatient clinic services. *FF21* The Hospital is projecting overall gains from operations in each of the first three years following the proposed termination. *FF22* Therefore, the Hospital has demonstrated that its proposal is financially feasible.

This proposal will not negatively impact care for Medicaid recipients and indigent persons. CCMC and CHC-NB provide services for any patient in the region, regardless of their ability to pay. Many community-based pediatricians in the greater New Britain area accept Medicaid patients and are willing to accept Medicaid pediatric patients from the Hospital. *FF24*

Access to health care services for residents of this area in need of inpatient pediatric medical and outpatient pediatric clinic services will continue despite the proposed closing of the Hospital's pediatric inpatient unit and outpatient services in New Britain. CCMC will be able to provide a greater array of pediatric focused services than the Hospital currently offers for its pediatric inpatient population. CHC-NB will be able to provide greater accessibility to the Hospital's clinic patients, in terms of services and hours of operation as well as coverage during non-operating hours. Several of the area private practice providers also have hours of operation that are greater than the Hospital's clinic service. Further, CCMC, CHC-NB and the majority of other community-based pediatricians provide services to Medicaid and indigent patients. The Hospital has demonstrated a clear public need for the proposal. Moreover, the Hospital has demonstrated that the proposal is consistent with the Statewide Health Care Facilities and Services Plan by reducing unnecessary duplication of services.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application of The Hospital of Central Connecticut for the termination of its pediatric inpatient medical and outpatient clinic services is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

2/10/2016
Date

Janet M. Brancifort
Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Greer, Leslie

From: Durdy, Barbara <Barbara.Durdy@hhchealth.org>
Sent: Thursday, February 11, 2016 9:16 AM
To: Greer, Leslie
Cc: Roberts, Karen; Huber, Jack; Foster, Tillman; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: RE: The Hospital of Central CT Final Decision

Thank you Leslie.

Barbara A. Durdy
Director, Strategic Planning

Hartford HealthCare

Hartford HealthCare

181 Patricia M. Genova Blvd.

Newington, CT 06111

Office: 860.972.4231

Cell: 203.859.8174

barbara.durdy@hhchealth.org

www.hartfordhealthcare.org

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Wednesday, February 10, 2016 5:28 PM
To: Durdy, Barbara
Cc: Roberts, Karen; Huber, Jack; Foster, Tillman; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: The Hospital of Central CT Final Decision

Ms. Durdy,
Attached is the final decision for The Hospital of Central Connecticut.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca